TOWARD A SHARED DIRECTION FOR HEALTH IN ONTARIO

Report
of the
Ontario
Health
Review
Panel
June 1987

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Hon. David Peterson
Premier of Ontario
Queen's Park
Toronto, Ontario

Dear Premier Peterson:

The Ontario Health Review Panel is pleased to submit its report in fulfillment of the terms of reference of the review process as set out in the Order in Council of November 6, 1986 (Appendix I).

The Panel interpreted its mandate as providing its "best judgment" to you on a general direction for health in Ontario and identifying some specific issues to be examined further in order to strengthen, improve and guide the evolution of health and health care in the Province of Ontario. Our advice is based on the collective wisdom and experience of the Panel members who reflect professional, provider and consumer interests and the geographic diversity of Ontario. Our perspective was enhanced by a broad range of advice received in written submissions from individuals and organizations across the Province, by presentations from senior officials across the Ontario government and by reviews of existing information.

The Panel defined its objective as the identification of three priority issues. These issues are addressed within a framework of values which we believe should be demonstrated in both the promotion of the health of Ontario's residents and in the further development of our health care system. The values also provided a benchmark to assess the current "health" of the system.

Arising from our priority issues, we have identified a range of ideas and options to be examined further, subject to the Government's acceptance of these issues as the priorities for further consideration and action.

Acknowledging the high quality of health and health care in the Province, the Panel concluded that it was preferable to build on existing strengths rather than attempt to redesign the system.

Ultimately, we believe that the process of effecting change is more important than the differences between recommended courses of action. To this end, we have recommended a mechanism which we believe is essential to securing commitment to implementation of the directions we have proposed. We believe that ongoing joint participation by individuals and health care providers with government in responding to these issues and proposed solutions is essential. Active participation will help us not only to sustain current achievements but also to respond effectively and efficiently to future challenges in the promotion of the health of Ontario residents and in the provision of the highest quality health care.

Yours very truly,

John R. Evans, M.D., Chairman

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REPORT OF THE ONTARIO HEALTH REVIEW PANEL
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EXECUTIVE SUMMARY

INTRODUCTION

The Premier of Ontario appointed the Ontario Health Review Panel in November 1986 to review the health status of Ontario's residents and the health care system in Ontario. The Panel's membership included representatives of various areas of Ontario, health care providers, consumer organizations and researchers.

A FRAMEWORK FOR HEALTH AND HEALTH CARE

The Panel reviews the health status of Ontario's residents and the health care system within a framework of a broad concept of health which goes far beyond the absence of illness and disease. We also identify seven values--equity, quality, comprehensiveness, informed choice, accountability, cost-effectiveness and commitment to the future--as benchmarks for assessing health and health care and for directing us to the issues which require resolution.

OVERALL ASSESSMENT

Based on a review of available information, 235 submissions, invited presentations and the reports of similar committees from the past fifteen years, we reach the conclusion that Ontario's residents enjoy a high standard of health. Ontario also has developed a good health care system which is relatively cost-effective compared to other Canadian provinces and other countries. There are pressures for change, however, created by rising public expectations for health care, constraints on public resources and frustration of health providers caught in the middle.

There is a remarkable consistency and repetition in the findings and recommendations for improvements in all the information we reviewed. Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention. The Panel notes with concern that well-founded recommendations made by credible groups over a period of fifteen years have rarely been translated into action.

THREE KEY ISSUES

A long list of potential issues could have been selected for consideration to bring the health of Ontario's residents and the health care system closer to the ideal as expressed in the Panel's values. The Panel, however, selects three general issues which it feels might provide an overall direction for health in Ontario and a context in which more specific problems might be addressed.

STRENGTHENING THE ROLE OF THE INDIVIDUAL

Ontario has not yet achieved the proper balance between the contributions of the individual to good health and health care and the contributions of health care providers and government. We are not "blaming the victim" of illness or misfortune or attempting to discourage people from using the health care services they need. Rather, we explore concrete ideas to achieve a partnership between the individual Ontario resident and the health system.

A variety of potential actions are identified to support healthful choices and to support informed choices by individuals.

A sensitive but important challenge is identifying opportunities for ensuring appropriate use of the system through incentives to patients and providers to balance rights with responsibilities. We could not agree on new financial measures to reinforce patient responsibility in using services wisely due to the lack of good information on the existence of perceived patient abuse of the system and lack of consensus on suggested measures. In the absence of incentives for patients, the individual provider is faced with both a responsibility to the patient to deliver high quality care and a responsibility to the system to control costs. Health care provider rights are discussed in recognition of this complex role.

LINKING THE ELEMENTS OF HEALTH CARE DELIVERY AND INCREASING THE EMPHASIS ON AMBULATORY AND COMMUNITY-BASED CARE

Efforts to slow down the growth in health budgets will be frustrated unless new funding incentives and organizational arrangements are found to make more effective use of existing resources. The new approaches should improve the linkages among various levels of health services and related social services and place greater emphasis on care in ambulatory and community settings. Funding approaches and organizational arrangements are selected with a view to emphasizing health promotion and disease prevention, providing choice in health care delivery to both individuals and health care providers and utilizing potential for innovation both within the existing system and new funding and delivery arrangements.

The first approach involves the provision of funding incentives under the existing system of OHIP reimbursement of health care professionals and global budgeting of hospitals. The funding approach also includes the use of capitation payments as another option in addition to fee-for-service and global budgeting. Capitation payments provide fixed rates to the professional for an individual patient over a given period of time regardless of the amount of health service required by the patient.

The second approach involves organizational arrangements for linking the various types of health care services to each other and to related social services, both within the existing system and under alternative delivery mechanisms.

We stress that many of these ideas are not new but have not been widely understood or implemented.

ACHIEVING A STRATEGY FOR HEALTH IN ONTARIO

With the vast public and private resources devoted to health and health care ($14.5 billion in 1985) and the high priority assigned to health by Ontarians, the continued lack of a mutually accepted strategy is the most pressing issue for immediate resolution. Without a strategy which involves government broadly and at the highest level, it is unlikely that policies of diverse ministries which affect health will receive adequate attention or that the difficult decisions on changing priorities in health care will have the political commitment needed for implementation. At the same time, successful implementation will depend on the collaboration from the outset of others outside government-- individuals, communities and the providers of health care.

After reviewing available mechanisms for developing the strategy, we conclude that a new mechanism is required with a broader mandate and joint participation from key groups both inside and outside the Government. We therefore recommend the establishment of the Premier's Council on Health Strategy, chaired by the Premier of Ontario or his designee. The Premier's Council should have 15-18 members with approximately equal representation from the three groups with the greatest impact on decision-making in health and health care: Provincial Cabinet Ministers, health care providers and individual residents. The Premier's Council should become a forum for the clear articulation of priorities, the resolution of conflict and the formulation of new policy initiatives.

The Premier's Council should be supported by a valid and reliable information system, adequate staff resources who are accountable to the Cabinet Office and local strategies developed by strengthened District Health Councils and local Boards of Health.

ESSENTIAL FIRST STEP

The Ontario Health Review Panel was requested to indicate a process for a subsequent phase of in-depth examination of options for implementing the general directions identified for the Government in the first phase of the review process. We urge that the Premier's Council on Health Strategy be established as soon as possible to ensure that the next phase is conducted by the Government in a partnership with health care providers and individuals in Ontario.

ONTARIO HEALTH REVIEW PANEL

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I - A FRAMEWORK FOR HEALTH AND HEALTH CARE

In this first chapter of our report, we provide our definition of health and health care. We also describe a set of values which we believe should be used as benchmarks to assess health and health care. The definition and values form our overall framework for the review.

MANDATE

The mandate of the Ontario Health Review Panel is to review the health care system in Ontario. Such a review cannot take place without a sensitivity to the determinants of health which extend beyond the formal health care system. We spent considerable time therefore discussing the many dimensions of the concept of health and we developed a view of health that is comprehensive, integrated and positive. It is a view that builds on earlier concepts of health and sets them in the context of today's challenges.

PREVIOUS DEFINITIONS

Our framework includes the perspective put forward by the Honourable Marc Lalonde in 1974 which stated that health was influenced by a number of factors including human biology, lifestyle, the organization of health care and the environment in which people live. It also supports the message by the Honourable Jake Epp in his 1986 report, "Achieving Health for All", that "health is a part of every day living and an essential dimension of the quality of our lives.... Health is thus envisaged as a resource which gives people the ability to manage and even to change their surroundings". This view recognizes freedom of choice and emphasizes the role of the individual and the community in achieving health. It also emphasizes a shared responsibility of the public, health professionals, and government to address the broader areas of public policy which affect the health of the population.

OUR DEFINITION

We adopted as our working definition the concept of health provided by the World Health Organization which is "the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical capacity".

SCOPE

We have interpreted the scope of our review in very broad terms in view of our definition of health and our reporting relationship to the Premier of Ontario. It is our responsibility to comment on the formal health care system which is generally accepted as hospitals and other organizations, health care practitioners and the legislative and funding responsibilities of the Ontario Ministry of Health. We have also included in our scope the related services of other government ministries which affect the health and well-being of Ontario's residents. Finally, we have considered the key influences on health arising from the environment, new technology, demographic changes and the lifestyle choices of individual residents.

THE FUNDAMENTAL VALUES FOR HEALTH

In considering this view of health, which goes far beyond the traditional concept of health as the absence of illness and disease, we have identified seven values as key principles to guide the direction for health in Ontario. These values are described below:

1. **Equity.** Each individual has equal opportunity to attain good health and to have access to appropriate health care services.

2. **Quality.** Health care is concerned with the quality of life, which emphasizes adding "life to years", not just "years to life". Health care is also devoted to quality of care which implies a competent and considerate provision of care.

3. **Comprehensiveness.** The health care system includes a broad spectrum of activities directed to health promotion, disease prevention, illness diagnosis, treatment and rehabilitation and the development of coordinated health policy. The system also encourages continuity and flexibility among the various parts.

4. **Informed choice.** The individual is entitled to take an active part in the decisions or choices which affect his/her health. The individual is also expected and given an opportunity to provide input into the level, extent and development of health care services in his/her community.

5. **Accountability.** Within the context of a health care system that is built on the principles of universality and accessibility, providers and consumers have a mutual obligation to use resources appropriately and responsibly.

6. **Cost-effectiveness.** The provision of health care services is concerned with the optimal balance among cost, appropriateness and quality of care and efficient utilization of services.

7. **Commitment to the future.** Investment decisions are required in a number of new areas of innovation to ensure the continuing excellence of the system and its ability to meet future challenges. Health promotion, reduction of environmental health hazards, health research, education and innovation in the organization and

financing of health care are key areas of commitment to the future. This process may involve reallocation of existing resources as well as new resources, both within and beyond the formal health care system.

IMPLICATIONS

By selecting a very broad definition of health and health care, we have not limited our scope to traditional concerns and solutions to problems. We believe that true change can only be effected from a perspective which encompasses many direct and indirect influences on health and health care.

We have set out our values at the beginning of this review in order to clarify what we believe are the indicators of good health and good health care. The values will also serve as benchmarks for assessing health and health care and for directing us to the issues which require resolution. If the selected issues are resolved, we believe that health and health care in Ontario will come closer to achieving the ideals as stated in the seven values.

II - OVERVIEW OF HEALTH AND HEALTH CARE IN ONTARIO

The purpose of this chapter of our Report is to give our best judgment of the strengths and weaknesses of health and health care in Ontario, based on the values we have established. In order to arrive at our assessment, we present the following:

- Health status in Ontario.
- The health care system.
- Pressures for change.
- Synthesis of previous reports and advice to the Panel.
- Recurrent themes from reports and other advice.

HEALTH STATUS IN ONTARIO

The health of Ontario's residents has improved significantly in recent decades. Furthermore, indicators of the health of Ontario's residents compare favourably with indicators of health in other provinces and other developed countries. While there are no comprehensive data on health status in Ontario, a review by Professor Larry Chambers (February 1987) cited the following concerns:

- Lower health expectations exist for the poor residents of the Province. The poor have shorter life expectancy and higher probability of prolonged disability. These discrepancies are particularly strong among men.

- Higher levels of chronic health problems and psychiatric disorders among children are noted in families on welfare.

- There are higher rates of infant mortality and of preventable infectious diseases, such as measles, mumps and rubella, in northern areas of the Province.

- Rapid growth in Acquired Immune Deficiency Syndrome (AIDS) has occurred since 1979.

- There are about 400,000 work-related injury compensation claims in Ontario each year.

- Although from 1975-1980 per capita alcohol consumption in Ontario was stable, alcohol was associated with between 45 and 54 percent of fatal motor vehicle accidents and liver cirrhosis is the sixth leading cause of potential years of life lost.

- Thirty percent of Ontario residents still smoke. Smoking has been linked to numerous diseases, including cancer and heart disease.

We believe that a process for monitoring health status and setting health status targets is essential for planning health care services, health protection services, health promotion and prevention efforts and for education and training of health professionals. The health status data available in the Province are not collected on a routine, comparable basis. The data are also not well linked to the planning and management of health promotion and health care delivery in the Province. These issues are currently being examined, however, by a Panel on Health Goals for Ontario appointed by the Minister of Health and chaired by Dr. Robert Spasoff.

THE HEALTH CARE SYSTEM

Expenditures

In 1985, approximately $14.5 billion was spent on health care in Ontario. This figure represents over $1,600 per person. Approximately 65% of the 1985 spending on health care was accounted for by the provincial government's health care budget. About 30% was private spending, such as personal spending on dental care, eye glasses, drugs and user co-payment for ambulances, nursing home care and contributions to hospital capital fundraising programs. The remaining 5% was direct federal government spending, municipal government spending in public health and workers' compensation. (See Exhibit 1.)

In the 1985/86 fiscal year, the Ministry of Health's budget represented 32% of all the provincial governme.it's expenditures. About 43% was offset by revenue transferred from the federal government. Another 18% of the provincial government's health care spending was covered by revenue from Ontario Health Insurance Plan (OHIP) premiums. The balance (39%) was provided through general provincial tax revenues. (See Exhibit 2.)

The breakdown of the Ministry of Health's expenditures are described below and summarized in Exhibit 3.

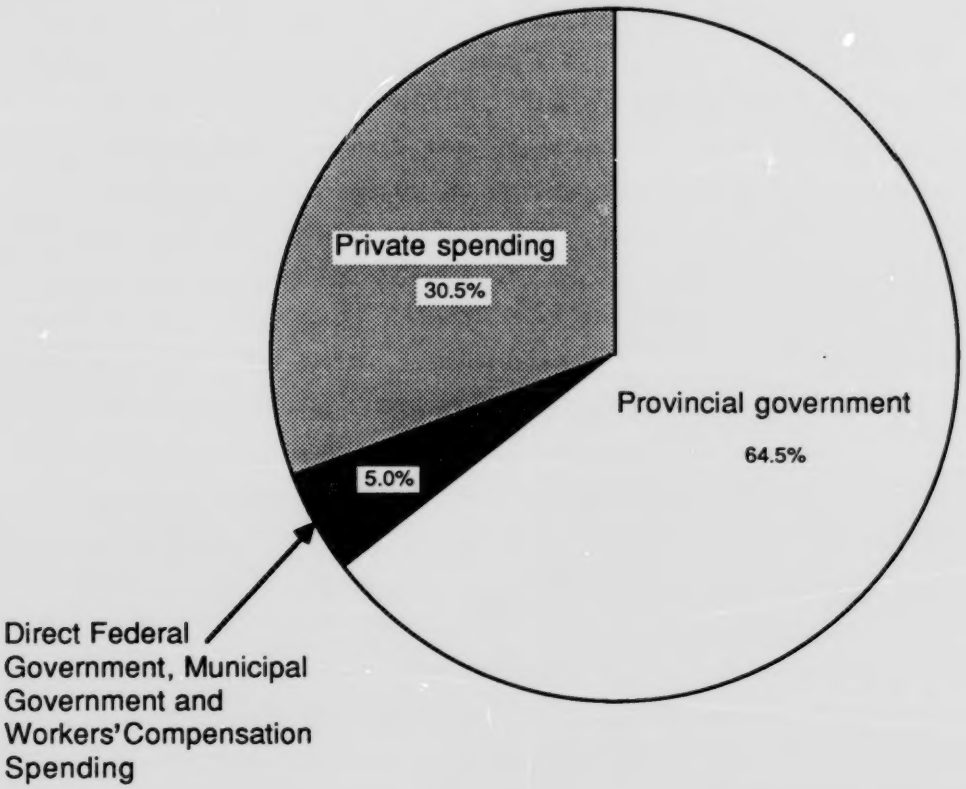
Hospital Care

Hospital care accounted for 52.6% ($4.9 billion) of the Ministry of Health's spending on health care in the 1985-86 fiscal year. If physician services reimbursed under OHIP and provided to patients in hospitals were included in the hospital category, the proportion of the provincial health expenditures spent on health care services in hospitals rises to $5.7 billion which represents 62% of the Province's health spending.

EXHIBIT 1

Breakdown of all Health Care Expenditures In Ontario in 1985

Total 1985 expenditures: $14.5 billion

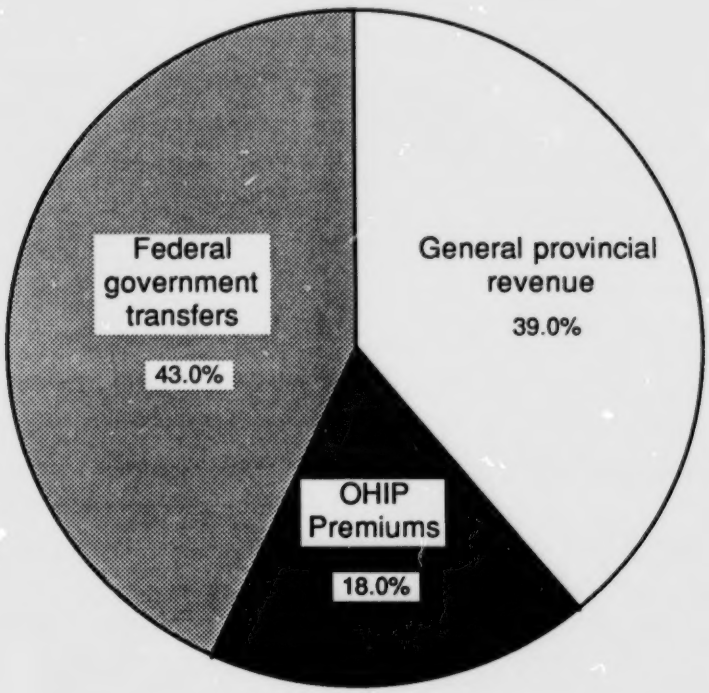


SOURCE: Health and Welfare Canada, National Health Expenditures 1975-1985, Ottawa, 1986

EXHIBIT 2

Breakdown of Ministry of Health Revenues in the 1985-86 Fiscal Year

Total 1985-86 Ministry of Health revenues: $9.264 billion

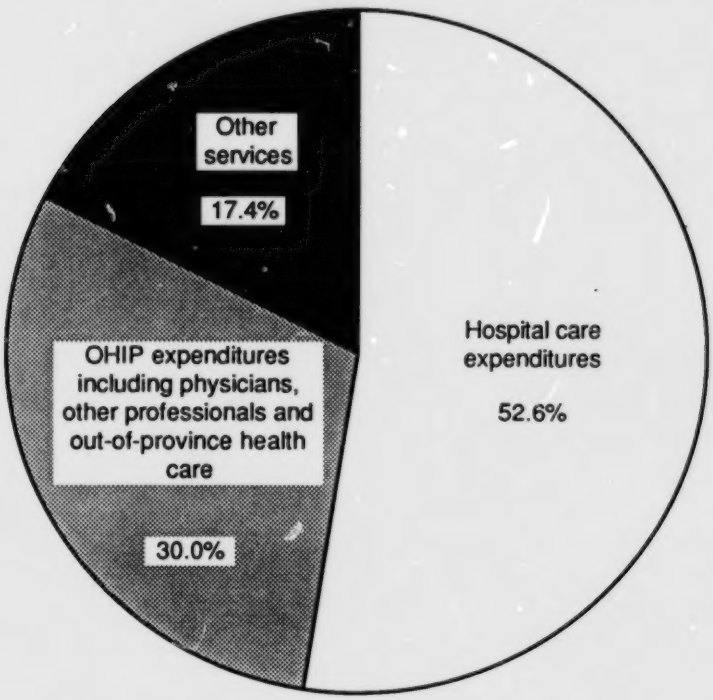


SOURCE: Ontario Ministry of Treasury and Economics,
Public Accounts 1985-86 Volume 1 (Financial Statements), Toronto, 1986

EXHIBIT 3

Breakdown of Expenditures by the Ministry of Health in the 1985-86 Fiscal Year

Total 1985-86 Ministry of Health expenditures: $9.264 billion



SOURCE: Ontario Ministry of Treasury and Economics, Public Accounts 1985-86, Volume I (Financial Statements), Toronto, 1986

Most hospital services, including salary and benefits for nursing staff, allied health professional staff and physicians employed in hospitals, are reimbursed on the basis of global budgets--fixed operating budgets set by the Ministry of Health annually for each hospital. While hospitals have made reasonable efforts at cost control, concerns have been raised that the global budget approach does not provide adequate incentives for hospitals to provide care efficiently, especially when supplemented routinely by budget deficit coverage. There are insufficient incentives to ensure that hospitals provide any given service at the least cost or to ensure that services are used in a cost-effective manner. An example of the inefficient utilization of hospital services is the many hospital beds being occupied by elderly patients whose hospital stays are prolonged because appropriate discharge arrangements cannot be found in the community. It is common for between 10% and 20% of the acute hospital beds in any Ontario city to be occupied by such patients. Global budgeting provides hospital administrators no financial incentive to solve this problem. If anything, there are slight financial advantages for the hospital in retaining such patients since they generally require less intensive, less expensive care than would be the case if the beds affected were filled with active-care patients.

Physician Services and Other Services Under OHIP

Services covered by the Ontario Health Insurance Plan (OHIP) represented another 30.0% ($2.8 billion) of the provincial government's 1985-86 spending on health care. Of this amount, $2.5 billion was spent on physician services, less than $100 million on out-of-province hospital services for Ontario residents and about $150 million on other health professionals such as optometrists, physiotherapists, dentists, osteopaths and chiropractors. Physician services are generally reimbursed on a fee-for-service basis. That is, physicians are paid according to a Province-wide fee schedule for each diagnostic procedure and treatment they perform on patients. Fee-for-service also applies to most physician services provided to patients in hospitals. Of the $2.5 billion spent on physician services reimbursed

under OHIP, almost $850 million (34%) was spent on services that physicians provided to patients in hospitals.

Concerns have been raised about the incentives implicit in the fee-for-service arrangement. Physicians have some discretion over the number of visits, procedures and tests that are recommended for any given patient's medical needs. An exception to the fee-for-service reimbursement method is the Health Service Organization (HSO) which is funded on a per capita basis for each patient served. In 1986, 180,000 Ontario residents--about 2% of the population--were served through HSOs. Another exception to the fee-for-service reimbursement method is the salaries paid to physicians who are employed by Community Health Centres (CHCs). CHCs, which provide primary care services to certain special need communities, are funded on the basis of global budgets.

Other Services

Approximately 17.4% ($1.6 billion) of the provincial government's 1985-86 spending on health care went for other services including home care, public health services, nursing homes, drugs, assistive devices (e.g., wheelchairs and physical aids), emergency health services, institutional and community mental health services and Ministry of Health administration. Most of these services are delivered independently of one another and have their own respective funding arrangement with the Ministry of Health. In general terms, home care, nursing homes and assistive devices are funded on a service volume basis. Public health and mental health services are generally funded on a fixed budget basis.

Organizational Structure

The Provincial Government

The health care system of Ontario is, in very large part, directed and funded through the provincial Ministry of Health. The Ministry has recently been reorganized into divisions corresponding with the main types of health services: institutional services (hospitals and nursing homes), mental health services, community health (public health, home care, health promotion, community programs), emergency services and special health services. The exception is physician services and related OHIP-insured services funded under an administration, finance and health insurance division which centralizes the payment for all OHIP-insured services. The method by which OHIP-insured services are administered tends to emphasize financial management rather than program and policy. The funding and delivery of services in each program area have tended to evolve separately over time, resulting in a variety of distinct funding mechanisms and approaches to service delivery. There is less orientation to the total health needs across populations served by various divisions of the Ministry. The creation of a policy, planning and systems division is recognized as an effort by the Ministry to take a more integrated approach.

Other Ministries in the provincial government are also involved in the funding and operation of health care services. The Ministry of Community and Social Services is central to this discussion. Long-term care for the elderly and disabled, for example, entails considerable overlap between the Ministry of Health and the Ministry of Community and Social Services. Both Ministries are involved in the funding of institutional care facilities and in-home services for chronically ill and dependent individuals. The complexity of the interface between the two Ministries is exemplified by the Integrated Homemaker Program which covers visiting homemaker services for the frail elderly and disabled. The program is funded by the Ministry of Community and Social Services but is administered and delivered through local Home Care Programs which are funded by the Ministry of

Health. Another area of overlap between these two Ministries is in mental health services. Although the Ministry of Health funds mental health services for adults, the Ministry of Community and Social Services funds most mental health services for children. This arrangement gives rise to serious transitional problems for individuals reaching an age where they are no longer eligible for children's services.

A third Ministry with a significant role in the funding and delivery of health care is the Ministry of Labour. It is responsible for a broad range of occupational health and safety programming as well as services for injured workers.

In the area of health policy, other Ministries in addition to Health, Community and Social Services and Labour are involved. These Ministries include the Minister Without Portfolio for Senior Citizens Affairs in the coordination of policy for the elderly, the Ministry of Colleges and Universities in health manpower planning and education, the Ministry of the Environment in regulating the quality of the physical environment and the Ministry of Housing with respect to housing programs affecting various populations.

In summary, a number of provincial Ministries are involved in policy, funding and program delivery for health and health care. There is considerable overlap and potential for lack of coordination as each Ministry develops and provides services to the same or similar populations which have a number of needs. Other provinces have attempted to resolve this problem through mergers of health and social services, but no ideal organizational structure has been documented.

District Health Councils

There are at present 26 District Health Councils in Ontario which plan and coordinate local health care services in response to local needs. Within the policy framework of the Ministry of Health, the Councils identify area

health needs, assess alternatives, establish priorities and plan comprehensive health care programs at the local level.

District Health Councils are solely advisory to the Minister of Health and therefore have no authority to manage or fund services at the local level. The funding of services remains centralized in the Ministry of Health. The management of services is divided between the Ministry of Health at the provincial level and among the boards of directors of individual hospitals, community organizations, public health and private health practitioners at the local level. There are few incentives to integrate the management or funding of the network of health care services at the local level although integration is being attempted by individual providers and the District Health Councils.

District Health Councils have evolved to different levels of effectiveness in influencing Ministry policy and planning. Improvements have been made, but opportunities exist for improvement in communication between the Ministry and the District Health Councils.

Local Delivery System

While the provincial government plays a key role in funding health care services, a variety of organizations and individuals deliver services at the local level:

- All major hospitals other than provincial psychiatric hospitals have independent boards of directors.

- Self-employed physicians and other private health care practitioners are reimbursed under OHIP and the Workers' Compensation Board.

- Public health is delivered by health units under the auspices of municipal or regional government and governed by local Boards of Health.

- A number of non-profit agencies and organizations provide health care services, such as visiting nurses services and homes for the aged.

- The private sector includes many long-term care facilities (e.g., nursing homes and residential care facilities), medical laboratories, private home care, counselling and other services.

Health Manpower

Health services draw upon a broad range of health professions, including physicians, nurses, allied health professionals and others. In a well-planned health care system, the number of individuals trained and available for work in each type of profession should correspond with current and anticipated health needs of the population and the preferred approaches to delivering health care. A review of existing research on health manpower in Ontario by Professor Jonathan Lomas (February 1987) included the following conclusions:

- The number of physicians in relation to the population has increased by more than 2% a year in recent years. In 1983, there was one physician for every 512 residents in the Province. Over the last 15 years, the proportion of physicians who are specialists has remained quite consistent at slightly less than 50%.

- Although the ratio of nurses to the population has increased steadily, there is a shortage in major urban areas of nurses trained in specialty services.

- Manpower planning efforts should take account of the changing health needs of Ontario residents and new health care delivery options. There is a need to train more professionals in the management of chronic illness, rehabilitation and palliation to meet the changing health needs of Ontario's residents. In addition, there are specialized needs such as health care research.

- Manpower planning cannot be done in isolation for the Province of Ontario. The extent of interprovincial migration of professionals indicates a need for interprovincial coordination of manpower. The immigration and emigration of health professionals to and from Canada supports the need for a federal-provincial approach.

Careful monitoring of trends in health manpower is required to assure the human resources required to meet future needs and to avoid undersupply in some professions and specialties and oversupply in others. After a long period of growth and development of the health professions, there may be a change of interest level in Canada if other countries may be used as a guide. In the U.S., for example, a decline has occurred in applications from qualified candidates for medicine, dentistry and nursing.

PRESSURES FOR CHANGE

There are a number of pressures to change health care in Ontario including the following: the rising expenditures on health care; the changing demographic make-up of the Province; changes in the patterns of illness; changes in public expectations of health care; and new technology.

Rising Expenditures on Health Care

The per capita expenditure on health care in Ontario increased by 50% between 1981 and 1985. This increase greatly exceeded the 27% inflation during the same period. The per capita increase in Ontario was less than the increase in some provinces and greater than the increase in other provinces for the same period. The increase in expenditures in Ontario was in the middle of the range when compared with rates of increase in other countries for the same period. Within the total increase in Ontario, some areas of health care expenditure increased faster than others due to a complex set of factors including increases in capacity, unit costs, demand for service and inflation.

While Ontario's health care expenditures do not seem excessive by inter-provincial or international comparisons, they account for nearly one third of total provincial expenditures. Further increases in expenditures to address unmet needs will be subjected to intense scrutiny. The Panel believes that the real opportunity to make progress lies in improving the cost-effectiveness of the system so that the maximum health benefits for Ontario residents can be achieved for any given level of financial resources from government, organizations and individuals.

Changing Demographic Make-up

The importance of ensuring an appropriate approach to meeting the health care needs of the elderly is underlined by projected demographic changes. While the population of Ontario as a whole is projected to grow by only 14.1% in the 20 years between 1986 and 2006, the population aged 65 years and over will increase by 50.2% and the population aged 75 and over will grow by 81.4%. On average, the population aged 65 years and over, and even more strikingly, those 75 and over, use disproportionately more health services, particularly hospital services, than the rest of the population. Researchers have also shown that the per capita use of health

services by the elderly has increased significantly in recent years. Data do not indicate that increased service use has necessarily led to more favourable health outcomes.

There is evidence that additional community-based services are required to meet the needs of the elderly. In most acute hospitals, elderly patients are awaiting discharge to appropriate community settings. Many terminally ill patients who are being cared for in hospitals could be cared for in their homes more humanely and efficiently if the services they needed were available in the community. Chronically ill patients are institutionalized because of a lack of publicly funded community services to care for them and to support their family caregivers.

Changing Patterns of Illness

A further pressure on the Province's health care system arises from changes in patterns of illness. Research shows that more and more illness and disability is accounted for by chronic diseases of long-term duration, rather than acute illnesses. About nine-tenths of all years of impaired health experienced by individuals is due to various categories of long-term disability. These trends imply that if significant progress is to be achieved in improving the quality of life for those who are ill and impaired, greater emphasis should be placed on long-term care services. Such services should give priority to supporting individuals in the community, enabling them to be as independent as possible and to come as close as possible to leading normal lives. Equally important, more attention should be directed to research on improved methods of prevention and rehabilitation for these individuals.

Changing Public Expectations

Pressure to change the way health care is delivered also arises from changing public values and expectations. The public expects more from

existing institutions and individual health professionals. In addition, because of increasing concern over the quality of life associated with many forms of institutional care, particularly institutional long-term care, there are greater pressures to ensure that alternative community-based services are made available. Expectations have grown for publicly funded services that are of a more supportive, enabling nature such as homemaker services, meals on wheels, assistive devices and palliative care. Furthermore, pressures are growing not only for direct services to patients with care needs, but also for respite care services which assist families and friends with caregiving responsibilities.

New Technology

A major force for changing approaches to health care comes from advances in medical technology. These advances are providing new opportunities in diagnosis and treatment and in delivering some existing services in a more cost-effective manner. For example, many surgical procedures that previously required hospitalization can now be performed on an outpatient basis. Some new techniques of diagnosis and treatment are so expensive, however, that concerns have been raised as to how society can make them available to those individuals who could benefit from them.

A review of health technology in Ontario by Professor David Feeny (February 1987) drew attention to the following points:

- The emphasis to date on capital cost-containment as a mechanism for controlling the introduction of new technologies has failed to discriminate adequately between effective and ineffective technologies. New technologies should be rigorously evaluated with respect to clinical efficacy and economic efficiency before widespread adoption.

- Agencies at the provincial and national levels should identify, evaluate and disseminate information on new technologies in health care.

- Decision-makers in the health care system should use such information on new technologies in their planning and management of health care resources.

The Panel strongly endorses Professor Feeny's conclusions.

SYNTHESIS OF PREVIOUS REPORTS AND ADVICE TO THE PANEL

Previous Committees and Task Forces

Over the past 15 years, numerous committees and task forces have reviewed the state of health care and made recommendations on how it should be improved or redirected. We discuss below the most prominent reports prepared by these previous groups.

In 1972, a federal government project, The Community Health Centre in Canada, chaired by John Hastings, argued in its Report for "the immediate and purposeful reorganization and integration of all health services into a health services system to ensure basic health services standards for all Canadians and to ensure a more economic and effective use of all health care resources".

In 1973, a committee chaired by Edward Pickering and commissioned by the Ontario Medical Association identified the following needs in its Report of the Special Study Regarding the Medical Profession in Ontario:

- Enlarging the role of paramedical services.

- Improving in-home medical services and further development of alternatives to institutions.

- Coordinating the various elements of medical care and addressing the fragmentation of medical services among medical specialists.

- Reassessing the medical profession's role in the health care delivery system.

In 1974, the Report of the Health Planning Task Force, prepared by a committee chaired by Fraser Mustard and sponsored by the Ontario Ministry of Health, made numerous recommendations to achieve the following goals:

- Regionalizing health care planning and management.

- Integrating the delivery of primary and secondary care.

- Achieving a shift in focus to the community.

- Coordinating services.

- Increasing emphasis on prevention, health promotion and health maintenance.

In 1982, the Final Report of the Task Force to Review Primary Health Care, also prepared by a committee chaired by Fraser Mustard and sponsored by the Ontario Ministry of Health, included the following recommendations:

- Alternative primary care funding arrangements for Health Services Organizations (HSOs) and Community Health

Centres (CHCs) should be continued as "legitimate", "fully-developed" funding sources in a pluralistic system.

- A further task group should be established to review the primary care sector in-depth and include in its mandate: incentives for efficiency; decentralization; integration of primary and secondary care services; and the best mix of professionals.

In 1983, the Ontario Council of Health and the Ministry of Health published Health Care: the 80s and Beyond. Major directions emphasized in the report included the following:

- Focus on disease prevention, health promotion and individual responsibility.
- Multidisciplinary approaches to care.
- A shift to care in the home and community.
- Coordination of services.

In the course of reviewing these studies, the Panel also received presentations from Dr. Mustard and Dr. Brian Holmes, former Chairman of the Ontario Council of Health.

Individuals and Organizations

In late November and early December 1986, the Panel invited written submissions from individuals and organizations interested in health to aid the Panel in the setting of directions and priorities (see Appendix II). We were very encouraged by the response. Of the 200 organizations whom we

contacted directly, 112 replied. In addition, we received 123 responses to the newspaper advertisement.

The responses from interest groups did not differ markedly from those of individuals and organizations who replied to the newspaper advertisement. We were impressed by the positive tone of the responses. Many were extremely supportive, offering their resources to assist the Panel further. We were also impressed by the breadth of perspective of the majority of respondents, particularly the organizations and groups who set aside their special interests to write about Province-wide priorities for health and health care.

The majority of the responses reinforced many of the themes of previous studies. In many cases, these themes were illustrated by the particular needs and perspectives of the elderly, the mentally ill and the disabled. Advice was received in the following areas, among others:

- Integrating the organizations and funding of health services, particularly at the community level of care.

- Changing funding arrangements to provide for more effective use of expensive resources and encouraging new services, particularly for those individuals with chronic handicap and disease.

- Expanding the scope of the Government's mandate for health and health care to include strategic planning and coordinated policy to address the social, economic and environmental determinants of health status.

- Greater emphasis on preventive care.

- More flexible use of health manpower, including integrating education for health professionals with the service delivery needs of the Province.

- The importance of additional resources for health research.

- Ethics and values with respect to new forms of conception, genetic engineering and the prolongation of life through life-support systems.

- Children's mental health and special education policy and programs.

Current and Former Government Officials

The Panel also placed a high priority on receiving a wide range of perspectives from within the Ontario government as to the interrelationships among Ministries in the field of health and health care and the issues which should be addressed.

Presentations were received from the current Minister and Deputy Minister of Health and also from former Deputy Ministers of Health.

The Panel also received presentations from the following Ministries whose activities were relevant to our deliberations: Colleges and Universities, Community and Social Services, Environment, Labour, Tourism and Recreation and Treasury and Economics. We also received presentations from the Office for Senior Citizens' Affairs, the Office for Disabled Persons, the Ontario Advisory Council for the Physically Handicapped, the Ontario Advisory Committee on Multiculturalism and Citizenship and the Ontario Human Rights Commission.

The Panel found a high degree of consensus in the government presentations. A recurring theme was the importance of effective care in the community to maintain health, prevent illness and rehabilitate individuals who have experienced acute or chronic illness. With respect to the training of health professionals and delivery of health care services, there was emphasis on the importance of the sensitization of care providers to the diverse linguistic requirements and multicultural practices and beliefs of Ontario's residents.

There was also a priority attached to reflecting the multicultural and multiracial composition of Ontario society in the recruitment of both staff and volunteers for the management and delivery of health care services. Similarly, there was universal acknowledgement of the need for interministerial approaches to the needs of the elderly, disabled and the mentally ill. There was also agreement that the current approach to planning services is fragmented not only between but within Ministries. The Panel was particularly encouraged by the degree to which various Ministries and agencies wanted to find mutually agreeable means to continue Ontario's high quality of health and community services and to address new opportunities and challenges.

RECURRENT THEMES FROM REPORTS AND OTHER ADVICE

We believe that a number of recurrent themes emerge from these reports, submissions and presentations, including the following:

- Placing a greater emphasis on **primary care.**
- **Linking** primary and secondary care.
- Achieving a **community focus** to care.
- Encouraging a **pluralistic** health care system.
- Focusing on health **promotion** and disease **prevention.**
- Achieving coordinated **planning.**

- Using a more **efficient mix** of professionals to deliver services.
- **Coordinating** services.

The most striking characteristic of all the above input is the consistency and repetition of many findings and recommendations. We observe as well that the repetition implies a **lack of effective implementation** of well-founded ideas from credible sources.

OUR BEST JUDGMENT OF THE HEALTH STATUS OF ONTARIO'S RESIDENTS AND THE QUALITY OF THE HEALTH CARE SYSTEM

What is our best judgment of health status of Ontario's residents and the state of health care in Ontario? We present an analysis based on our seven values, followed by an overall conclusion.

Equity

Opportunities remain to achieve greater equity in health status. Researchers have shown that lower income individuals have a significantly lower life expectancy and a greater likelihood of illness and prolonged disability than those with higher incomes. A few communities in the Province, such as some Indian settlements in particularly remote areas, experience a level of health that is very far below that of the rest of the Province.

Considerable progress has been made in achieving equity of access to health care. Most Ontario residents are free of any significant financial barriers to obtaining the health services they need. The most serious constraint to access today is related to the availability of services in northern and remote areas. People living in these areas still find that they have to travel considerable distances to obtain certain basic services.

Problems are also experienced with access to services in some urban communities. Some individuals from new immigrant populations may experience problems in acquiring full access to service due to language barriers or lack of knowledge. While progress has been made, physically handicapped and other disadvantaged groups experience difficulty in acquiring full access to the health care system.

Quality

The technical quality of health care provided in this Province, particularly in the treatment of acute illness, is recognized to be of a high standard that compares favourably with other countries. Concern has been raised about two other dimensions of quality which are particularly important in chronic disease. First, the "caring" element of health service which can affect both medical outcome and patient satisfaction is perceived to be lacking in some agencies and facilities. Secondly, the quality of life in health facilities such as some hospitals and nursing homes has been challenged as inadequate.

Comprehensiveness

While Ontario has established a comprehensive range of health services that includes the most important types of service for caring for the ill, there are opportunities for improvement. Better linkage among the various types of health services, including hospitals, family doctors, home care and institutional long-term care should lead to better balanced allocation of health resources and savings in expensive treatment and support services. Such linkage would facilitate access to the most appropriate and cost-effective service and continuity of care for patients with changing health needs.

Informed Choice

In general, we believe that information is available for individuals to make many of the choices affecting their health and the level of services available in the community. The system does not provide full and easily accessible information in all cases, however, leading to difficulties for some individuals. This problem is especially common among various disadvantaged and dependent populations.

Concerns have also been raised in recent years regarding the need for a more active role for the patient or consumer in selecting or consenting to the type of health care received. Some examples are the management of child birth, death with dignity and consent to psychiatric care.

Informed choice also requires involvement of the public in the planning of health services and in other aspects of the community which affect health. Information is often not available to members of the public, however, to support their involvement. There is a great need for the public to understand where their money is spent and what it is buying. The public also needs to understand other key determinants of health (e.g., poverty, environment, housing, nutrition) if they are to influence policy decisions in these areas.

Accountability

Accountability for health care is focused on the individual caregiver or institution. Mechanisms exist for accountability in the delivery of health care, such as professional colleges overseeing the practices of their respective professions, hospital accreditation and the reporting requirements of the Ministry of Health. We believe, however, that accountability is inadequate in two important respects.

First, there is no single focus of responsibility to the individual for the total management of his/her health care, including providing services appropriate to need. Family doctors have little responsibility for the overall health care resources their patients consume or the care that they receive in other settings such as hospitals or home care. Even within hospitals, responsibilities for patient care tend to be diffuse and are often shared among a number of different health professionals and departments operating with some degree of automony. Techniques exist, and more are being developed, which would facilitate improved monitoring of the appropriateness of care including utilization standards and clinical outcome standards. Such techniques offer an opportunity to provide clinician managers, health administrators and board of directors with useful information on the effectiveness and management performance of their organizations.

Secondly, accountability rests largely with the health care system rather than with the individual who consumes health care services. In many cases, neither the individual nor the health care system can be held responsible for the factors and conditions leading to ill health. At the same time, ample evidence exists that unhealthy lifestyles contribute to various forms of cancer, cardiovascular disease and other fatal or chronic disorders which place tremendous strain on our health care resources. Some of the determinants of health are heavily influenced by the physical and social environment but individual behaviour is a powerful contributor. Further opportunities exist to reduce the threats to health and at the same time to reduce the heavy burden on health care resources. Mechanisms are needed to enhance the accountability of the individual to avoid health hazards under his/her own control and to use health resources judiciously.

Cost-Effectiveness

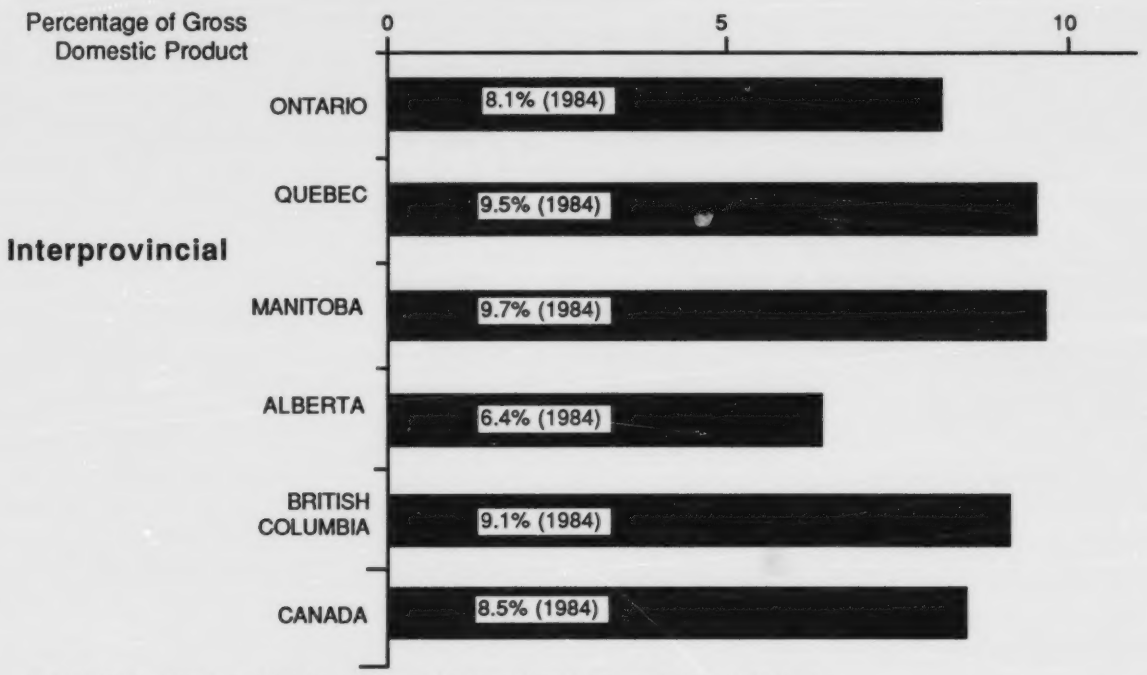
Precise comparisons of the cost-effectiveness of Ontario's health care systems with other provinces and other countries is difficult. Available information on health care expenditures and health indicators from Ontario and other jurisdictions does not suggest that Ontario is atypical. In 1984, Ontario spent 8.1% of its Gross Provincial Product (GPP) on health care, compared to an average of 8.5% of GPP for all Canadian provinces. Internationally, the United States, for example, spent 10.6% of its Gross Domestic Product on health care in 1983. (See Exhibit 4.) While Ontario's expenditures are considerably lower than those in many jurisdictions, Ontario's health outcomes are not markedly different. There is considerable evidence, however, that further improvements in the cost-effectiveness of our health services can be achieved, particularly through more appropriate utilization of services, including a shift in emphasis from institutional to community-based services. More attention could be directed to evaluation of existing health care services, alternative models of service delivery and the effectiveness of given techniques to determine the best approach available for a given level of expenditure.

Current funding arrangements for health care in Ontario do not provide adequate incentives to providers to ensure that patients are cared for in the appropriate setting and that they receive the appropriate level and duration of services. Evidence of inappropriate care can be found throughout the Province's health care system, from inappropriate institutional admissions to overuse of medications among the elderly.

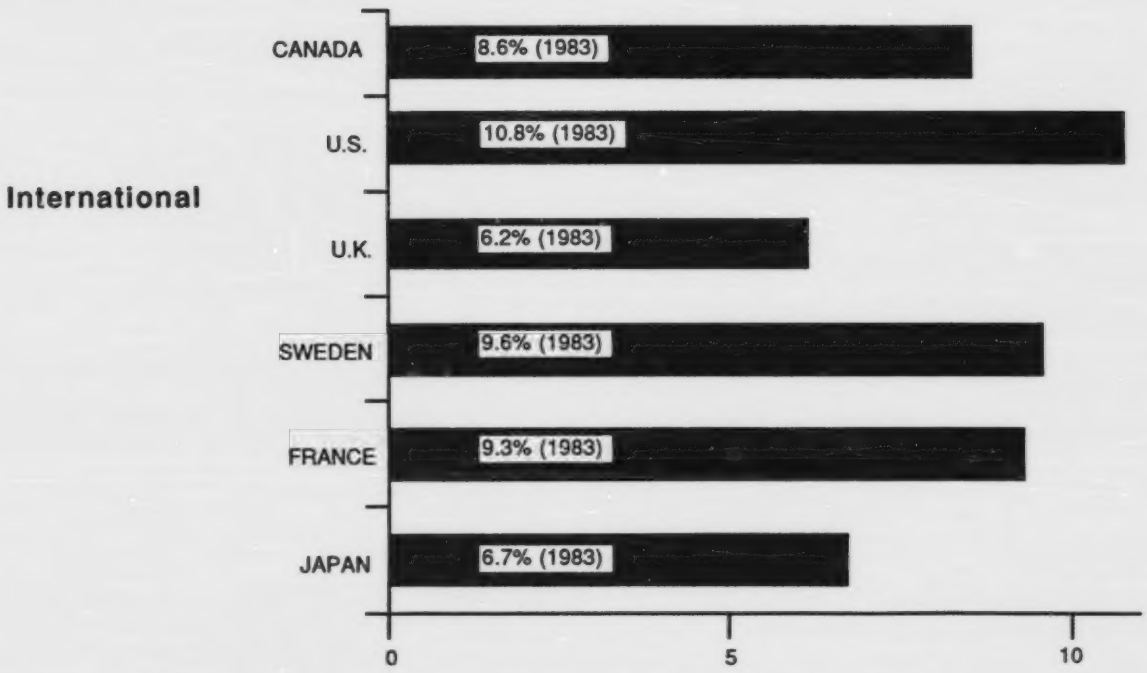
Many patients who could enjoy a higher quality of life in their homes or through community-based services are being treated in institutional settings. Evidence suggests a significant proportion of hospital admissions could be avoided. The length of hospital stay could be reduced. Some patients now being cared for in long-term care institutions--including nursing homes and chronic hospitals--could be cared for in their homes

EXHIBIT 4

Comparison of Total Expenditures on Health Care as a Percentage of the Gross Domestic Product in Selected Jurisdictions



SOURCE: Health and Welfare Canada, National Health Expenditures, (1975-85)



SOURCE: Organization for Economic Cooperation and Development, Measuring Health Care (1960-83)

with the appropriate level of home care and support for their family caregivers. Care provided on a community basis is also more likely to address the problems that contribute to the patients' illnesses than treatment provided in a detached, institutional context.

Commitment to the Future

Investments of resources to maintain the current health care system take priority in most jurisdictions over investments for long-term health benefits. We believe that certain programs likely to have significant future benefits for various populations should be strengthened, such as promotion of healthy lifestyles, avoidance of substance abuse by adolescents and support for the disabled to live independently. The quality of the environment will continue to have a significant effect on health. The health system should have a greater capacity to monitor, evaluate and anticipate the health impact of environmental pollution.

Commitment to the future also requires increased investments in research not only in understanding disease and new forms of diagnosis, treatment and prevention, but also in the evaluation of better approaches to the organization, financing and delivery of health care and health promotion. Many world-renowned contributions to medical and health-related research have emanated from Ontario's medical and other professional schools. In recent years, these schools have found it increasingly difficult to maintain or initiate research programs as a consequence of a relative decrease in both federal and provincial funding. There are few sources of funds available for applied clinical research. The ability to close these funding gaps from "academic enrichment funds", contributed from fee-for-service income generated by physicians based in teaching hospitals, has been strained. While the recently announced intentions of the Government of Ontario to provide more funds for research are welcome, we believe that increased public and private funds for research are required as part of Ontario's commitment to the future.

OVERALL CONCLUSIONS

In summary, we believe that the majority of Ontario's residents enjoy a high standard of health. We also believe that Ontario has developed a very good health care system. Our conclusions are based on many objective and subjective indicators which indicate that we have improved the health of our residents and developed a system which meets most of our values. These accomplishments reflect the significant investment of resources by government in the health care system and the quality and commitment of health care providers across the Province.

We also believe that the health of Ontario's residents and the health of the system could be further improved by dealing with shortcomings which require immediate attention. The shortcomings in the system need to be addressed with vigor if deterioration in health status and in the quality and cost-effectiveness of health care is to be avoided. We believe that Ontario as a society will support actions and long-term investments which have the potential to promote health and to improve the quality of the health care system.

III - THREE KEY ISSUES

Based on our high but qualified rating of health status and the health care system and the opinions expressed to the Panel, a long list of potential issues could be prepared that require resolution in order to bring our system closer to the ideal. The Panel elected, however, to limit attention to a small number of central issues. We believe that this strategy will increase the likelihood that our review will lead to focused discussion and tangible results.

In this chapter, we briefly introduce three issues which we believe should be addressed. Each issue is discussed separately in Chapters IV, V and VI.

We stress that these three issues are not placed in priority order, as we believe they are all important and require attention. Rather, we have ordered the issues based on a sequence which we believe is consistent with the values cited in Chapter I.

STRENGTHENING THE ROLE OF THE INDIVIDUAL IN HEALTH AND HEALTH CARE

The Issue

Ontario has not focused sufficient attention on the role of the individual in health and health care. In other words, we do not have a clear understanding of the proper balance between the contributions of the individual to good health and health care and the contributions of health care providers and government.

A focus on a proper balance between the roles of individuals and providers should contribute to the resolution of the growing gap between demand for services and supply of resources. We are not supporting policies or attitudes which "blame the victim" for being sick or which would lead to further inequities of health care between rich and poor or the various advantaged and disadvantaged groups in Ontario. Rather, we wish to build upon existing health promotion activities, patients' rights proposals, efforts by providers to be more accountable through quality assurance programs and other avenues which may contribute to a more balanced and active relationship between the provider and the individual consumer. We also focus on the rights and responsibilities of the individual health care professional in relation to the hospital or other service organization, the consumer and other professionals.

Our Values

In terms of our values, the **equity** of both access to health care and improved health status would be increased through a better understanding of individual needs, rights and responsibilities. A focus on the provider and the individual would empower the individual to exercise **informed choice** about one's own health and the health options in the community. The emphasis on balance between providers and the individual would bring stronger **accountability** mechanisms into place.

LINKING THE ELEMENTS OF HEALTH CARE DELIVERY AND INCREASING EMPHASIS ON AMBULATORY AND COMMUNITY-BASED CARE

The Issue

Ontario has placed insufficient emphasis on linking the elements of health service delivery and on service provision in ambulatory and community-based settings. These shortcomings have contributed to a number of problems. An overconcentration of health care resources exists in the institutional care sector, hospitals and chronic care facilities. There is

evidence of inappropriate use of both acute and long-term inpatient beds with unnecessary admissions and unnecessarily long lengths of stay. A separation of inpatient care in hospitals from other types of health services delivered in the community has been noted, along with inadequate support for treatment in the community and home environment.

A health care delivery system that continues to rely heavily on institutional forms of service delivery will result in health care which is more expensive and which often fails to respond to the needs and preferences of individuals. Opportunities will continue to be missed to prevent illness and to reduce the need for expensive services. Furthermore, unless a shift in the emphasis of health care to community-based services is achieved, it is uncertain whether the health care system will have the flexibility and capacity to meet the future needs of the frail elderly, physically and developmentally handicapped and the chronically ill.

Our Values

With reference to our values, the **quality** of health care would be improved as more emphasis is placed on treatment and prevention on an integrated basis. The **comprehensiveness** of our health care system would be improved as individuals will have increased access to appropriate care closer to home with reduced travel to remote facilities. The **cost-effectiveness** of the health care and related systems would be improved through an emphasis on ambulatory and community-based care as we minimize the very high capital and operating expenses associated with inpatient institutional care.

ACHIEVING A STRATEGY FOR HEALTH IN ONTARIO

The Issue

Ontario has been unable to develop and implement a commonly understood and accepted strategy for health. In other words, many other substantive

issues including the two issues described above cannot be resolved unless an improved process is implemented for planning and managing the health care system and the related initiatives affecting our health. We believe that an improved planning process and a better strategy would force us to confront this challenge, to seek creative alternatives and to make tough decisions.

Our Values

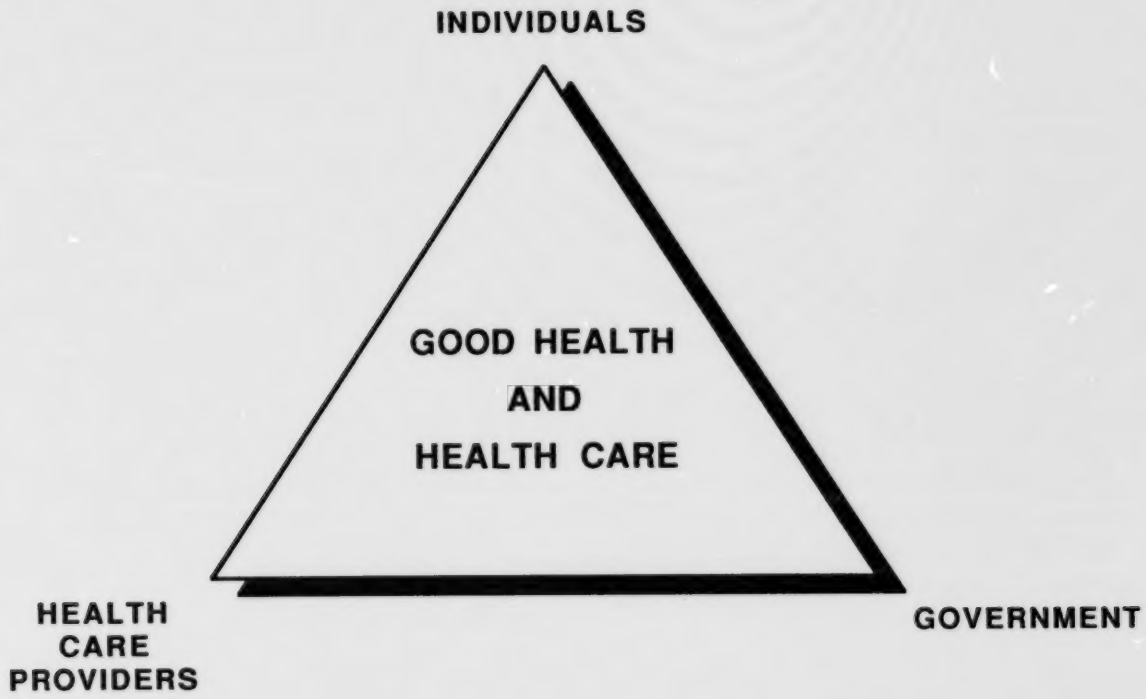
We believe that **all our values**, particularly **commitment to the future**, will be met more effectively by the development of a strategy for health for Ontario. Without a strategy which is widely understood by individuals, communities, providers and government, it will be difficult to mobilize the resources and commitment required to cope with changing health needs as identified in the two preceding issues.

CONCLUDING REMARKS

The three issues selected are closely interrelated. They address our values, current economic realities and pressures for change. Taken together, they offer a direction for health in Ontario and a context in which individuals, health care providers and government can address more specific problems, as shown in Exhibit 5.

EXHIBIT 5

TOWARD A SHARED DIRECTION FOR HEALTH IN ONTARIO



IV - STRENGTHENING THE ROLE OF THE INDIVIDUAL IN HEALTH AND HEALTH CARE

THE ISSUE

New directions for health and health care begin with the needs of individuals. Consideration should be given to the individual's right to live in a healthy environment and to have access to an appropriate range of high quality services. These rights should be balanced with the individual's responsibility to participate in developing a healthy environment and to utilize valuable health care resources appropriately. Health care providers and government have an important role in enabling individuals to exercise these rights and responsibilities.

CONTEXT

The health care systems in Canada and other advanced societies have reached a point where the rising expectations of both individuals and providers are placing strain on the financial resources of society. Very large expenditures are involved in heroic terminal care and in new technologies such as organ transplants, artificial organs, advanced life support systems and other complex interventions. Some of these measures are requested by patients and families but in many cases decisions associated with individual health care are made in effect by the health care provider. Enhancing the role of the individual patient in decision-making is often difficult since many "decisions" have one clinically sound choice which is strongly urged upon the patient by the health care practitioner. Nonetheless, consumers of health care services are increasingly interested in being better informed and in participating in decisions affecting their health. Greater accessibility to information should bring the provider-patient relationship closer to a true partnership.

The individual's opportunity to make decisions affecting his/her health extends beyond health services. Personal decisions on lifestyle and risk taking strongly influence health. Factors often beyond individual control such as income, educational attainment, employment, housing and family status also materially affect health. In Ontario, regional disparities are evident, the most striking being the difference in health status between residents of different parts of Ontario. It is important to identify these disparities, understand their causes and enable individuals to take control where possible of those things which determine their health.

Our discussion of the individual therefore recognizes the rights and responsibilities of the individual for decisions but also recognizes that societal forces exert strong pressures on the individual which often make this process difficult.

SCOPE OF THE ISSUE

Our concern in this issue includes three areas. First, we are interested in the relationship of the individual to the traditional elements of the health care system. An important factor in this relationship is the increased understanding of health matters by the individual in order to establish a more balanced relationship with the provider and to facilitate informed choice in the utilization of services. Secondly, we are concerned with the relationship of the individual to the physical and social environment. Included in this area are the general physical environment (e.g., reduction in air and water pollution) and the workplace (e.g., reduction in exposure to hazardous chemicals). The social environment includes socio-economic status, societal attitudes regarding health and health care, geographic location in Ontario and the support the individual receives from the community. Finally, we are interested in exploring opportunities for the individual to modify personal behaviour in order to reduce self-imposed dangers to health. Included in this area are approaches which support healthful lifestyle choices (e.g., cessation of smoking) and which help develop personal skills in order to reach one's full potential.

GOALS FOR THE INDIVIDUAL

As a preamble to our proposed goals for the individual, we state our support for the fundamental rights of the individual to receive health care, to refuse treatment, to maintain the confidentiality of information and to other basic considerations. We also believe that patients should have the right of access to providers and/or health care organizations of their choice.

Within the overall context of the fundamental values we set out in Chapter I and the above preamble regarding patients' rights, the following three goals are proposed.

Supporting Healthful Choices

Ontario's residents are becoming increasingly aware and interested in the positive results of healthful lifestyle choices in such areas as diet, alcohol and tobacco consumption, exercise and stress management. Policy should support individual choices in these areas. We should also recognize that positive change in individual behaviour is more likely when steps are taken to make change more convenient and socially acceptable. When the social and psychological determinants of unhealthful lifestyle choices are understood, the choices are more subject to modification.

Supporting Informed Choice by the Patient and the Family

For the consumer of health care services, informed choice is supported by increasing individual autonomy in order to develop a more balanced partnership between the individual and the health care provider. An individual's right to ask questions, to seek alternatives to a recommended treatment, to participate actively in decision-making and to judge the results of

health care services should be supported. A necessary condition for these decisions is the existence of real choices for the consumer of services (e.g., various forms of care for the elderly).

Ensuring Appropriate Use of the System

Each individual should be assured of receiving high quality, appropriate care for a given illness, problem or need in a caring environment. A key value within this goal is to ensure that each individual enjoys maximum independence in living. The roles of the family and the local community are critical to supporting this independence in a caring environment. Each individual should also be able to use our health care system to the full extent required to achieve maximum potential while using our health care resources appropriately.

Overall Thrust

Our overall intent is to empower individuals and their families to achieve their full potential for health. For the consumer of health care services, our overall purpose is to bring the individual and the health care provider into a partnership in decisions on health diagnosis and treatment and in the appropriate utilization of health care resources.

POSSIBLE ACTIONS

How can we achieve these goals? In the next few pages, we will present a range of possible actions which build upon our existing system. We believe that each of these ideas has merit but some require further elaboration, analysis or demonstration.

Supporting Healthful Choices

Based on a coordinated effort by government, business, labour, local communities and individuals, the following actions may be taken to support healthful choices by the individual:

- Restriction of smoking in the workplace.
- Early passage of worker and community right-to-know legislation regarding hazardous materials used, produced or disposed of in Ontario.
- Development of specific programs directed at grocery stores and restaurants to assist individuals in healthful food choices.
- Development of programs such as the campaign to reduce impaired driving that involve more than one level of government and more than one ministry.
- Strengthened health curriculum in schools.
- Basic health information prepared on various diseases, disorders, treatments, environmental hazards, lifestyle choices, etc.

Supporting Informed Choice of Health Services by the Individual and the Family

A number of avenues may be followed to support informed choice:

- Periodic provider surveys of patient satisfaction.

- Well-publicized avenues for complaints by patients in provider facilities and agencies.

- Increased information on health status through such mechanisms as the following:

  - Full access by patients to their hospital records upon request.

  - Individualized health diaries prepared and updated by health care professionals and retained by patients.

- Increased information about services available through the following:

  - Access to information on the location of accredited services and the qualifications of professionals.

  - Access to information on options available for inpatient care and community-based services to the elderly, the physically and developmentally handicapped and the mentally ill.

  - Access to information on alternative health care delivery organizations and their potential benefits and limitations.

  - Crisis intervention telephone lines in the emergency departments of each major hospital for poison control and other emergency information.

  - Provision of written information with each initial prescription on possible side effects, contraindications and other important facts.

  - Identification for the patient of all professionals involved directly in the patient's care.

- Leadership by the various health care professional associations, self-regulating colleges and professional schools in encouraging their respective professions to support the increased autonomy and active involvement of individuals in health and health care decisions.

- Acceptance of prior documentation of individual choices with respect to the use of life support systems and "heroic measures" in terminal disease or catastrophic accident.

Ensuring Appropriate Use of the System by Individuals

The provision of rights should be linked to the acceptance of responsibilities. In our universally accessible health care system, individuals should accept their responsibilities to use our health care system appropriately. We stress caution in this area, as we do not wish to discourage the sick from seeking treatment or to reduce equal access by the poor or other disadvantaged individuals to our system. We struggled nonetheless with the issue of perceived misuse of health care services by patients: unnecessary visits to emergency rooms and doctors' offices, excessive multiple consultations and investigations for the same problem and other similar concerns.

Patient Responsibility

In this context, suggestions are made for financial measures to reinforce patient responsibility to use health care resources appropriately. For example, when patients are left in hospitals after they are ready for medical discharge, it is reasonable to expect the patient and family to accept responsibility for charges for room and board if adequate notice has been given and a properly explained discharge and follow-up care plan exists.

It has also been suggested that information should be made available to the patient and health care provider on the total cost of all health care services used by the patient. While this information may have significant value in enhancing the management of resources by the provider, it is uncertain whether it will have an effect on utilization behaviour by the patient.

Beyond these two measures, we could not reach agreement on additional financial measures to reinforce patient responsibility to use services wisely for several reasons. First, the extent of abuse is not well-documented. Available evidence suggests that even the definition of what constitutes abuse is not uniform among health care providers. Secondly, what appears to some health care providers as frivolous use of the system may represent genuine anxiety on the part of the patient and the family. Furthermore, what appears to government to be misuse or overuse of certain diagnostic or treatment procedures by health care providers may be considered appropriate by the providers in relation to patient needs. Finally, most of the suggested measures to increase consumer "responsibility", such as coinsurance, user fees and tax back systems, are based on the belief that more direct financial participation of the individual will lead to more responsible use of services. The concern remains that such measures will also deter individuals from seeking necessary services in favour of financial benefit. Furthermore, these proposals place a portion of the burden of health care costs on those individuals who are ill which

conflicts with the basic principle of the health insurance system in Canada.

Role of the Provider

The control of access to services falls principally on the health care provider. The provider, whether a professional, agency or facility, is placed in the middle of a tug-of-war between patients' rights and expectations on the one hand and the concern of governments to limit expenditures on the other hand.

The current attention to the control of access emphasizes provider responsibilities with less emphasis on provider rights. Respect for individual provider rights, however, may be necessary to motivate the high degree of professionalism expected of health personnel and to support the stated goals of the self-governing professions.

We accept the principle of freedom of choice by the provider in serving individual patients. This principle, however, is subject to certain constraints. First, the provider has a duty to ensure alternate care is available to the patient. Second, professionals who accept salaried employment may have their choices limited according to mutually accepted conditions of employment requiring that mandatory service be provided to all patients admitted to the agency or facility.

All health professionals should have the right and the responsibility for self-regulation which includes the concept of public accountability. All professionals should have the right to a peer review committee and to a complaint and discipline process which should protect the right of the patient to confidentiality and the reputation of a professional from unjustified defamation.

All health care professionals have both the right and the responsibility to practice ethically and to exercise the best professional judgment in the

interest of the patient. At the same time, health care professionals should recognize a responsibility to be cost-effective in the selection of diagnostic investigations and treatment or therapeutic interventions.

Provider Interactions

Another dimension of the role of the individual provider is the appropriate interactions among the various health care providers who may provide service to the same patient or patients. Similarly, we should also focus on the interface between the practitioner and the facility in which the practitioner works. For example, efforts of hospitals to foster quality assurance and cost-effectiveness are highly desirable. These efforts can be expected, however, to create conflict for the professional who attempts to provide the highest quality care while being concerned with costs. Our primary concern is the need to encourage effective cooperation and to reduce any intergroup tensions in the interests of meeting both patient needs and of maintaining an appropriate environment for all providers.

The many individual practitioners who provide service are partners in a system which demands both high quality care and cost-effective use of our health care resources. At the same time, the professions are seeking to maintain or enhance their sense of professional independence from government funders, facilities and sometimes from each other. Inevitably, conflicts among and between professions may arise from these demands. Equally, conflicts between professionals and government may arise. Appropriate mechanisms must be found which support dispute resolution.

We believe that both government and health care providers have a responsibility to become more effective in achieving a balance among the competing demands placed on health care professionals, either individually or in groups. Accreditation programs, for example, should incorporate expectations regarding effective mechanisms for internal communication and consultation.

In summary, a delicate balance should be maintained between the rights and responsibilities of various professions within the context of the independent professional's role as both caregiver and gatekeeper.

CONCLUSIONS

In this chapter of our Report, we have reviewed the role of the individual in health and health care. We draw the following conclusions:

- There are rising expectations of rights in the health system on the part of individuals and families as patients and on the part of individual professionals who provide services.

- The individual has rights and responsibilities which should be understood within limitations imposed by factors beyond the control of the individual.

- The health of the individual should be considered not only in relationship to the traditional elements of the health care system, but also in relationship to the physical and social environment and to opportunities to reduce self-imposed dangers to health.

- There are a number of methods available to support healthful choices by individuals and to support the ability of individuals to make informed choices.

- We could find relatively few tangible and acceptable measures by which patients' rights could be balanced with patients' responsibilities for judicious use of services and for sharing the general problem of reasonable cost control. Specifically, we could not agree on direct financial

participation of the individual for services as an incentive to responsible utilization of services or cost control.

- In the absence of financial incentives to patients for responsible use of services, the control of access to services falls principally on the health care provider. Provider responsibilities in this area have been emphasized with less attention to provider rights.

- There is a potential for conflict between groups over rights (e.g., between health professionals and between individual providers and the institutions which manage the delivery of services).

The lack of incentives within the existing health care system by which patients, providers and government could share more equitably the challenge of realistic expectations and realistic expenditures indicates an urgent need to seek alternative mechanisms to meet the challenge. We present in the next two chapters alternate financial and organizational mechanisms and a method for all interested parties to participate in developing a strategy for health and health care which have the potential for increased collaboration and reduced conflict.

V - LINKING THE ELEMENTS OF HEALTH CARE DELIVERY AND INCREASING EMPHASIS ON AMBULATORY AND COMMUNITY-BASED CARE

THE ISSUE

Health care providers are at a crossroads. On the one hand, they are experiencing unprecedented expectations from the individual patient for the highest quality care which is both comprehensive and accessible. On the other hand, the concern of government in our publicly insured health care system is to contain the large portion of provincial expenditures directed to health. At the same time, government must respond to pressures for expansion of the health budget to accommodate higher utilization, new technology and more hospital inpatient facilities, particularly for long-term care. Based on our analysis of information from Ontario and other jurisdictions, we conclude that efforts to slow down the growth in health budgets will be frustrated unless new incentives and organizational arrangements are found to make more effective use of existing resources. Put simply, health care professionals, health care facilities and government face a combined challenge to provide the most appropriate level of care in the most cost-effective manner.

BASIC PRINCIPLES

The Panel believes that we have an opportunity to improve health and health care in Ontario by introducing funding approaches and organizational arrangements which place greater emphasis on care in ambulatory and community settings and which improve the linkage among various levels of health services and related social services. Such care will, we believe, be more accessible to the user and will offer greater promise of contributing to the quality of life as well as the quality of health of the

individual. In selecting innovative funding and organizational approaches, the Panel has been guided by the following principles:

- Ensuring that health professionals and health care facilities promote health and assist the individual to reduce health risks.

- Ensuring that appropriate services are provided in an appropriate setting.

- Providing choice in health care delivery to both individuals and health care providers.

- Exploring the potential for innovation both within the existing system and through new delivery arrangements.

FUNDING APPROACHES

Incentives can be established through innovative funding approaches both within the existing funding system and through alternative funding mechanisms.

Existing Funding Mechanisms

Within the current system of OHIP fee-for-service reimbursement of physicians and global budget funding of hospitals, the following approaches could be implemented:

- Incentives to physicians and hospitals to provide tests and treatment and to perform operations on an outpatient basis. For procedures that can be done on both an inpatient and outpatient basis, incentives could be achieved

by setting hospital reimbursement and professional fees at a higher level for those procedures performed on an outpatient basis.

- Premiums for physicians to provide regular office hours on evenings and weekends. This incentive can be expected to increase accessibility, reduce pressure on emergency rooms and reduce the inconvenience and hardship imposed on patients who have difficulty coming to physicians' offices during normal working hours.

- Incentive payments for family physicians, similar to the Ambulatory Care Incentive Program which currently applies only to care provided in Health Service Organizations.

- Incentives to physicians for the provision of counselling on health promotion and disease prevention.

- Premiums for physicians to provide service in remote or other underserviced areas.

- Reimbursement penalties for hospitals and physicians when patients admitted to hospitals for diagnostic evaluation or surgery do not undergo the procedure by the second day of their stay. Careful planning will be required and allowances could be made in exceptional cases where a delay is justified.

- Reimbursement penalties for hospitals and physicians where the patient exceeds the expected length of hospital stay for a professionally selected list of diagnostic categories, adjusted for the type and severity of the illness.

- Incentives for the development of health services which result in the more efficient use of health care resources (e.g., preadmission testing, alcohol and drug abuse programs, hospice services, employee assistance programs, alternate birthing centres).

Alternative Funding Mechanisms

As an alternative to the existing funding system, health care providers including both health professionals and health care facilities can be reimbursed through capitation payments. This approach provides fixed fees to the provider to prepay for the health services that an individual patient may consume during a given period. The capitation payments are not related to the amount of services that the patient uses during that period, although they could be varied according to risk criteria such as age and health status. Capitation payments can be instituted to finance services at several levels:

- For reimbursement of primary care services (i.e., services from a family doctor and other front-line health professionals). This approach is used for reimbursing Health Service Organizations (HSOs). HSO funding also permits the inclusion of specialist physician services.

- For reimbursing health care organizations which integrate primary care with specialist services and hospital care. This arrangement is reflected in the concept of a Comprehensive Health Service Organization (CHSO) discussed in the next part of this chapter. It is also found in Health Maintenance Organizations (HMOs) in the United States.

Capitated approaches to reimbursement offer one option to control the amount paid for health care. They give health care providers incentives to achieve efficient utilization of services and reward providers who

emphasize preventive medicine and health promotion and optimize patient use of expensive hospital and specialty services. They also encourage efficient mixes of professionals in service delivery, since payment is not directly connected to the provider of the service.

One potential risk is that providers will adopt selective enrollment practices to attract healthy patients and discourage ill patients. This risk can be minimized by techniques to monitor both the health status of enrollees and enrollment practices.

No Single Approach

In examining these and other potential funding approaches, it is important to emphasize that no single approach will meet all needs. Rather, health care providers should be free to choose the method under which they prefer to practice. Consumers should also be made aware of the various options available and the potential benefits and limitations of each approach. Across Ontario, a blend of fee-for-service, global budget and capitated approaches may provide a range of choice well-matched to the diverse needs of consumers and providers.

ORGANIZATIONAL ARRANGEMENTS

Given the concern about the disconnectedness of the health care delivery system, attention should be directed to organizational arrangements which enhance service to the individual through improved linkages among various levels of health care and between health care and social services. The options which we highlight below are illustrative of the potential for innovation.

Organizations to Link Primary and Secondary Care

Health care provider groups and organizations could be developed to link primary and secondary care. Such groups or organizations could be funded through a variety of mechanisms, including the current global budget and fee-for-service approaches as well as capitated approaches. Also, such health care organizations could be initiated by different potential sponsors, including existing hospitals and professional organizations such as a local medical society. Examples include the following:

- **The multispecialist group practice** links primary and secondary care by a number of different medical specialists to facilitate the coordination of required services to the individual. This arrangement can be found both within fee-for-service practices and Health Service Organizations.

- **The Comprehensive Health Service Organization** (CHSO) is an approach which would take the current Health Service Organization one step beyond primary care to include hospital care and to make available a full range of specialist care, all within capitated reimbursement. The introduction of CHSOs could follow one of at least four possible scenarios. A CHSO could build on an existing HSO where the HSO adds inpatient care to its line of services. A CHSO could be developed from an existing hospital where the hospital initiates a primary care clinic. CHSOs could involve mergers of existing hospitals with existing HSOs or group practices. Conceivably, CHSOs could be all-new organizations, perhaps in underserviced areas or in areas of considerable population growth.

When new forms of health service delivery organizations such as Comprehensive Health Service Organizations are planned, consideration should be given to methods of encouraging consumers to take advantage of the services. These methods would have to be designed within the constraints of preserving Ontario's universally accessible health care system. Particular features that might make such new organizations more attractive to consumers include single point of access to all required services, a broader range of services than are currently insured under OHIP and more convenient hours of business.

Organizations to Link Hospital Care and Home Care

Many patients upon discharge from hospital receive home care from area-based home care agencies funded through the Ministry of Health's Acute and Chronic Home Care Program. The programs, however, have prescribed limits on the amount and intensity of care any patient can receive. Such limits do not necessarily reflect any consideration of the most cost-effective approach to caring for the particular patient. There are several organizational options which would improve the integration of home care services with hospital care. Two of these options are outlined below:

- **Hospital organized home care** is organized directly by the hospital and funded out of the global hospital budget. This approach could facilitate earlier hospital discharges since there would be closer liaison with the hospital and greater potential for relying on hospital services to support the home care services. The result would be greater continuity in the follow-up care patients receive after discharge or after hospital-based ambulatory surgery. It could also be used to divert patients from unnecessary hospital admission.

- **Extramural hospitals** offer in-home services that are intended to provide a substitute for some hospital care. Funded under a global budget, extramural hospitals provide a full range of professional health services (nursing, laboratory, pharmacy, allied health professions, etc.) and the capacity to deliver such services around the clock. Physicians are involved in all phases of a patient's treatment and care management and provide in-home services. In-home nursing services are available on a shift basis. The approach also includes a follow-up home care program. The extramural hospital has been introduced in New Brunswick where its services are now available across most of the Province.

Organizations to Link Health and Social Services

There are a variety of arrangements for enhancing the integration of health and social services in the community. These arrangements will improve the quality, comprehensiveness and cost-effectiveness of care and the quality of life for the individual. Included are the following examples:

- **Multiservice centres** which are established by a community to provide health and social services in a single location. Where possible, they should build upon existing Community Health Centres.

- **Coordination and case management** of health and social services for specific vulnerable populations such as the frail elderly, the disabled and the mentally ill. The planned implementation of this concept for services to the elderly on a pilot basis in Ontario by the Minister for Senior Citizens' Affairs provides the opportunity to test its applicability to other special needs groups.

INFRASTRUCTURE FOR CHANGE

In order to realize some of the options discussed above, it will be necessary to effect certain changes in the infrastructure supporting the delivery of health and social services. These changes include the following:

- Improving the working relationships among government and all health professions in support of the health of the residents of Ontario.

- Strengthening communities through enhanced volunteer services as a support to professional services, including self-help groups for problems such as substance abuse.

- Encouraging organized groups to sponsor the development of new initiatives through funding for development and start-up costs.

- Broadening the education and preparation of health professionals to emphasize health promotion, ambulatory care and appropriate care of the elderly and chronically ill. Health professionals should also be trained to recognize their responsibilities for the management of resources for patient care and for the health of the larger community.

- Achieving the appropriate mix of health and social service professionals to correspond with the needs of patients.

- Developing data bases to compare new approaches with more established approaches to service delivery and to assess the feasibility and effectiveness of various options.

- Streamlining funding approaches and administrative arrangements among different types of health services.

PROCEEDING TO IMPLEMENTATION

We have identified a variety of funding approaches and organizational arrangements which should be explored in much greater depth. Demonstration projects should be undertaken to explore the feasibility and effectiveness of the various options. These demonstration projects will require significant planning and initiative at both the provincial and local level.

We believe that there is no one funding or health care delivery approach that is appropriate for all communities in the Province. There should be a pluralism in the arrangements for health care delivery to respond to the particular needs of the populations served and to offer choices to both patients and providers. The implementation of these options will not be possible, however, without the mutual participation of individuals, providers and government.

VI - ACHIEVING A STRATEGY FOR HEALTH IN ONTARIO

THE ISSUE

If Ontario is to resolve the extraordinarily complex and challenging issues outlined in the previous chapters, a mechanism must be established to act as the driving force in developing a clear strategy for health which is commonly understood and accepted. It must be the forum for strategic thinking to shift health to a higher priority on the public and political agenda.

While repeated surveys and our own analysis have documented a high level of satisfaction with our health and health care system, we believe that change is needed. This change will involve fundamental rethinking of rights and responsibilities, incentives, organizational arrangements and spending strategies to enhance health and the delivery of health care services. Such change will inevitably result in perceived and real gains or losses on the part of different interested parties. To maximize understanding of these changes and minimize the perception of losses, there must be a mechanism for the participants to be actively involved in and fully informed about the change process.

BASIC PRINCIPLES IN ACHIEVING A STRATEGY FOR HEALTH

Over the last twenty years, the Government of Ontario has established a variety of mechanisms to develop elements of a strategy for health. At the provincial level, the former Ontario Council of Health provided the advice of health professionals, educators and lay persons outside government to the Minister of Health on the health services system. Numerous task forces have also been struck as identified in Chapter II. Despite many good recommendations, however, few have been translated into action.

Most recently, the Minister of Health has developed a strategic planning process to establish Ministry priorities and directions to guide the allocation of resources by the Ministry for the next five years. At the local level, the primary role has been assumed by District Health Councils.

These provincial initiatives have been primarily concerned with health services. Their mandates have not stressed the broader determinants of health.

It is important to emphasize that each of these mechanisms has contributed a valuable perspective. They have tended, however, to be very different and often isolated perspectives of government, health care providers or local communities. There has as yet been no mechanism available to integrate these perspectives toward a shared direction. Consequently, there has been increasing evidence of frustration and alienation among the various stakeholders in health and health care.

In order to meet future challenges, the mechanism for developing a strategy for health at the provincial level must incorporate new guiding principles:

- **Joint participation** from the outset, not only by government, but by individuals and organizations external to government who have a fundamental impact on both the health of Ontario's residents and the health care which they receive.

- **A concept of health** which embraces the totality of an individual's well-being and addresses the determinants of quality of life as well as quality of care.

- **Integrated government policy** for health as the shared responsibility of many different Ministries whose programs and policies in the areas of occupational and environmental health, social welfare, housing, manpower training and research have a fundamental impact on the health of Ontario's population over and above the formal health care system.

- **Balance** between Province-wide and local perspectives which provides for flexibility, pluralism and innovation.

PROPOSED PROVINCIAL MECHANISM TO ACHIEVE A STRATEGY FOR HEALTH

The mechanism to develop a strategy for health in Ontario must provide for the clear articulation of priorities, the resolution of conflict and the formulation of new policy initiatives. It must have the highest level of political commitment since the ultimate decisions on a strategy for health in a publicly insured health care system rest with government, both in terms of public policy decisions and resource allocation. Government, however, is not the only stakeholder. An equally strong level of commitment must be secured from individuals and health care providers external to government to engage in an ongoing process of fundamental rethinking, change and innovation. There is no obvious model to draw from other jurisdictions.

Essentially, we believe that Ontario has both the opportunity and responsibility to take a leadership role. How can this leadership best be expressed?

PREMIER'S COUNCIL ON HEALTH STRATEGY

We recommend that the Premier of Ontario establish a Council on Health Strategy to demonstrate the highest level of commitment to explore new ways of approaching health and health care which involve all of the participants in the change process.

We believe that the participation of the Premier or his designee as Chairman is required, at least in the initial phase, to signal not only the highest level of governmental participation but also to command a similar commitment from external participants. The Premier's participation would also demonstrate the commitment of government to a concept of health which goes beyond the formal management of the health care system by the Ministry of Health. It would acknowledge that the health of Ontario's residents is influenced significantly by the broader social, economic and environmental policies and priorities of government as a whole.

Initially, the Premier's Council must set the broad assumptions and priorities to be addressed in a strategy for health. Over time, the Premier may wish to establish an ongoing mechanism which maintains broad senior level participation from both inside and outside government but which does not require the direct involvement of his office to the same extent.

Membership

The Premier's Council on Health Strategy should be large enough to encompass the essential perspectives of the individual and community, health care providers and government. At the same time, it must be able to function as a cohesive working group. Therefore, we would recommend that in addition to the Chairman, the Premier's Council be comprised of 15-18 members with approximately equal representation from the following three categories:

Individual and Community

- **The individual** - As the focus of health policy and the prime funder of the health system through taxes, the individual should be an essential contributor to the development of health policy. The "consumer" membership of District Health Councils provides an excellent opportunity to select lay representatives who have significant experience in local community planning and who can contribute local perspectives to provincial policy.

- **Business and Labour** - The viewpoints of business and labour should be represented because of their interests in effective use of premium and tax revenues for health and the importance of a safe workplace, a clean environment and a productive workforce.

Health Care Providers

- **Health Professionals and Health Care Facilities** - Representation from this group is perhaps the most difficult because it is so diverse, comprising physicians, nurses, allied health professionals, other human service professionals, hospitals, long-term care facilities, community health programs, public health and organizations serving special needs groups.

- **Health Education and Research Centres** - The universities, including the five health science centres, as well as the community colleges, play a central role in the education and training and deployment of health manpower, health research and technology development and assessment.

Government

- **Provincial Government** - Membership would be expected to include not only those key Ministers who have major policy, operational and funding roles in health care services, but also Ministers whose policies and programs have a significant influence in relation to determinants of the health status of Ontario residents. Participation by the Treasury is also essential for consideration of financial incentives and other funding arrangements required to implement a strategy for health.

- **Local Government and Federal Government** - While the size of the Premier's Council on Health Strategy may preclude designated membership for local government and the federal government, it is essential that there be the capacity to focus attention on complementary and conflicting policy directions which affect the health of Ontario's residents and the care which they receive.

Organization

The Premier's Council on Health Strategy should be the forum for establishing priorities to be addressed, recommending policies to the Government, ensuring that consideration has been given to a wide range of perspectives and resolving conflicts which may exist. The senior level of participation proposed from all sectors is essential to secure commitment to the subsequent implementation of a strategy for health in Ontario. At the same time, the other responsibilities of the participants limit the time commitment which can be expected. The Premier's Council should therefore be supported by the following:

- Ad hoc task forces and committees pertaining to specific issues within the strategy for health. These groups would be comprised of much broader representation than is possible within the Council.

- A small staff secretariat reporting to the Cabinet Office. The Council should also obtain professional staff as required from government ministries and external organizations which are represented on the Council and from other sources. This approach ensures a breadth of analytical and technical support.

- A comprehensive and accessible information system which provides data at both the provincial and local level for monitoring the health status of the population and evaluating the efficiency and effectiveness of health care services. The data must be considered valid and reliable by the participants in order to affect decision making.

In order to address both longer term and immediate priorities, the Premier's Council should establish a multi-year planning cycle (3-5 years) which provides for the articulation of longer term goals as well as an annual planning cycle which develops objectives and policy advice related specifically to the upcoming fiscal year.

SCOPE OF THE STRATEGY FOR HEALTH IN ONTARIO

The first challenge to be faced by the Premier's Council on Health Strategy is to determine where to begin in defining future directions for health and health care in Ontario.

We suggest that the Premier's Council must first define specific goals to achieve the improved health of Ontario's residents. The Honourable Murray Elston, Minister of Health, has taken an important first step in this regard by establishing the Ontario Health Goals Panel whose report and recommendations regarding specific measurable health goals for Ontario will be completed in the near future.

In his speech to the Conference on Health Goals for Ontario in April 1987, the Minister stated that "the health goals concept recognizes above all else, that health is affected by economic, social, cultural and geographic factors--and that goals can be set...that are relevant, measurable and tangible for every person in this Province".

We share the Minister's enthusiasm for health goals which "challenge our existing notions of health and the health care system". We strongly concur in his view that "health is central to our economic, social and cultural well-being. It should be on everyone's agenda".

Within the framework of health goals, a strategy for health must also deal with specific targets and priorities which can be measured, evaluated and implemented. These targets and priorities should include the following:

- An annual health "report card" which monitors the achievement in relation to the established health goals. The report card would contain a critical examination of the indicators and determinants of health status at both the Province-wide and local levels. The analysis would be derived from a periodic survey of the health status of the population.

- A multi-year plan which identifies key indicators of health status where there is a reasonable chance that public policy intervention would have a positive effect. The plan

must also include steps to enhance public motivation to reduce behaviour which undermines health.

- A comprehensive and integrated network of institutional and community services to meet both the social and health care needs of vulnerable populations including the frail elderly, disabled and mentally ill children and adults.

- A multi-year plan for linking health and other human services, as outlined in Chapter V, to facilitate the coordinated management of institutional and community services. This plan must include a critical examination of alternative systems of health care delivery and new incentives within the existing system.

- An integrated health manpower policy which is derived from the current and anticipated health needs of the population and the mix of institutional and community services and which recognizes the interdependence of Ontario with other provinces in manpower supply.

- A health care financing strategy which addresses new approaches and new incentives in the funding of health care facilities and in the remuneration of health professionals. The financing strategy should reinforce the organizational arrangements for the integrated management of the total health care system. It should also establish mutually acceptable approaches to dispute resolution.

- A provincial plan for the assessment and dissemination of existing and new technology in health care delivery which will serve as a catalyst for the development of interprovincial and national standards. This plan must comprise

not only criteria for dissemination of technology but also standards appropriate for utilization in patient care.

- An investment strategy which entails a multi-year commitment by both the private and public sector to invest in both basic and clinical health research and innovation in order to enhance Ontario's leadership role both at the national and international level.

IMPLEMENTATION OF THE PROVINCIAL STRATEGY FOR HEALTH

The implementation of the future directions in health and health care in Ontario requires strong linkages between the Premier's Council and the ongoing management and delivery of health and health care programs. Within the provincial government, the relationship to the Premier and the direct participation by the Minister of Health and other Ministers will ensure not only that their priorities are reflected in the strategy, but also that elements of the strategy are feasible and are reflected in the allocation of resources and the management of health and related programs. Outside government, there must be equally strong linkages established between the Premier's Council, health care providers and local communities to ensure that the priorities in the strategy are influenced by and reflected in the local organization and delivery of services at the local level.

A LOCAL STRATEGY FOR HEALTH

While a clear strategy for health is required at the provincial level, it is at the local level where the health of Ontario's residents is demonstrated and where the interaction between the provider and consumer of health care services takes place. As we have indicated in Chapter II, there is still inequity across this Province, not only in health status of the population, but in access to the most basic health care services. Therefore, there must be a mechanism at the local level not only to address the impediments to

improved health status, but also to establish priorities for the organization and delivery of health and related human services. Consistent with our emphasis in Chapter V on pluralism and diversity in organizing health care services, there must be sufficient flexibility to meet the unique needs and very different priorities experienced in northern areas, rural communities and large metropolitan regions.

While a new mechanism is recommended at the provincial level, at the local level we conclude that a new mechanism is not required. In reaching this conclusion, the Panel reviewed the role and mandate of District Health Councils and local Boards of Health. It is our view that District Health Councils across Ontario already reflect several of the basic principles in achieving a strategy for health. Their mandate includes a broad concept of health. Their membership is diverse, comprising health care providers, consumers, representatives of local government, business and labour. As agencies of the Ministry of Health, however, they are limited in their ability to influence or ensure participation of other areas of government or local human service providers. They have also been limited by the absence of a comprehensive information system on health status and health care services at the local level.

The development of an information system provides an opportunity for Boards of Health to assume a much more significant and complementary role to District Health Councils. In many communities across Ontario, Boards of Health have the greatest awareness of the health status of the population as a result of their mandate for health promotion and disease prevention. This information is the essential foundation of a local data base for planning and evaluation of health promotion strategies and health care services.

On balance, we believe that it is entirely possible for District Health Councils with the assistance of local Boards of Health to assume responsibility for the development of the local strategies for health. This respon-

sibility, however, requires that the Government of Ontario strengthen the capability of District Health Councils to take a more integrated approach to the many areas of public policy which impact on health and health care at the local level. Overcoming the jurisdictional boundaries between health and social services is of particular concern if local communities are to pursue the types of innovation which we identified in Chapter V.

District Health Councils must also be reinforced by a comprehensive information system and may require the infusion of more staff resources. This approach builds upon the strengths of an existing system and acknowledges the breadth of participation which already exists.

While the local strategies will inevitably be concerned with the allocation of resources to meet particular needs in terms of both health status and health care services, they must be conducted within a clearly understood framework of the broader provincial strategy. For example, the decisions of a local community on the most appropriate mix of health professionals to staff the network of health care facilities will be directly affected by a Province-wide health manpower strategy. The provincial strategy would affect the availability of various types of health care providers and the definition of the role that they play within the health care system. Therefore, strategies for health at the local level must be complementary to the provincial strategy.

Complementarity between the strategies for health at both the provincial and local level requires ongoing clear communication to District Health Councils of the elements of the provincial strategy as a framework for their detailed planning. At the same time, it is essential that local priorities and perspectives are clearly communicated to the provincial level in order to ensure that Province-wide strategies are relevant and sensitive to local realities.

ESSENTIAL FIRST STEP

As discussed in the previous chapters, the possible approaches to address our first and second key issues require detailed consideration by all the interested parties in order to formulate sound policies and to secure a commitment to the implementation of selected new directions. A decision by the Government of Ontario to implement a mechanism at the provincial level to develop these and other elements of the strategy for health is the first step, since it provides a signal of the Government's commitment to a shared direction among the participants. In addition, it will require a significant commitment on behalf of external participants. Furthermore, since we believe that there is urgency to move forward on the issues and possible approaches to their resolution, we recommend that the Government proceed as rapidly as possible to establish the Premier's Council on Health Strategy.

VII - CONCLUDING REMARKS

During the past fifteen years there has been a succession of constructive recommendations to improve the health care system in Ontario. The difficulty has been translating them into action. The current combination of pressures for change and constraints on resources will make actions even more difficult. It is in these circumstances that an environment of trust and shared commitment must be established among the public, providers and government.

The Ontario Health Review Panel has endeavoured to select issues and possible approaches to resolving them which present a collective challenge to the individual, health care providers and government. Ontario has an unprecedented opportunity to open lines of communication and broaden the base of participation in enhancing the health of its residents and shaping a health care system which is flexible and responsive to the diversity of needs across this Province. Ontario also has an opportunity to reach beyond health care to address the much broader environmental, social and economic determinants of health in our society.

The work of the Ontario Health Review Panel has provided an opportunity for collaboration among different interest groups in addressing very difficult issues. The process has also challenged each of us to shed the traditional concepts of health with which we began. Our experience suggests that while a significant commitment will be required from all parties, there is a readiness among individuals, health care providers and government to work in partnership toward a shared direction for health in Ontario.

This report marks the completion of the first phase of the review process established by the Order in Council for the Ontario Health Review Panel. It is the recommendation of the Panel that the subsequent stage of in-depth examination of the options for implementation of policies, envisaged in the terms of reference of the Panel, be conducted under the auspices of the proposed Premier's Council on Health Strategy.

APPENDIX I

ORDER IN COUNCIL
MEMBERSHIP OF THE ONTARIO HEALTH REVIEW PANEL
STAFF AND PROJECT TEAM

Ontario
Executive Council

Order in Council

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that

pursuant to section 9 of the Ministry of Health Act, R.S.O., 1980, Chapter 280;

(a) an advisory committee be established to be known as the Committee to Review the Health Care System in Ontario.

(b) the terms of reference of the said committee be:

(i) to examine the changing patterns of health services in Ontario, and trends in health manpower and technology, in relation to changes in the demographics and health profiles of the citizens of Ontario;

(ii) to examine incentives and mechanisms to maintain the quality and accessibility of health services, to encourage the most effective and economical use of health resources, and to stimulate greater attention to the promotion of health and prevention of disease;

(iii) to examine the relationship between health care professionals and the government with a view to maintaining professional autonomy;

(iv) to attempt to identify policies of high priority and to indicate a process for a subsequent stage of in-depth examination of the options for implementation of these policies.

(c) the following persons be appointed members of the said advisory committee

Dr. John R. Evans, Chairman
Toronto, Ontario

Ms. Mathilde Bazinet
North Bay, Ontario

Dr. A. MacPherson
Toronto, Ontario

Dr. Murray McAdam
Kitchener, Ontario

Sister Winnifred McLoughlin
Sudbury, Ontario

Ms. Dorothy Pringle
Ottawa, Ontario

Mrs. Rose A. Rubino
Toronto, Ontario

Dr. Hugh Scully
Toronto, Ontario

Mr. Greg Stoddart
Hamilton, Ontario

Mr. W. Vickery Stoughton
Toronto, Ontario

(d) the members of the said advisory committee be entitled to receive such per diem allowances as are approved by Management Board and be entitled to be reimbursed for all reasonable travelling and any other necessary expenses actually incurred in connection with the work of the said advisory committee.

(e) the Chairman of the said committee shall report the findings of the committee by the summer of 1987.

Recommended _____ Concurred _____
Minister of Health Chairman

Approved and Ordered November 6, 1986
Date

_____
Lieutenant Governor

MEMBERSHIP OF THE ONTARIO HEALTH REVIEW PANEL

John R. Evans, M.D. (Chairman)
Chairman and Chief Executive Officer
Allelix Inc.
Toronto, Ontario

Mathilde F. Bazinet, R.N., M.Ed.
Director of Nursing Operations
Medical Services Branch
Health and Welfare Canada (on leave of absence)
Former Chairman of Health Sciences
Canadore College
North Bay, Ontario

Alexander Macpherson, M.D., M.Sc.
Medical Officer of Health
Department of Public Health
City of Toronto
Toronto, Ontario

Murray McAdam, M.D.
Family Physician
Past President of Ontario Medical Association
Kitchener, Ontario

Sister Winnifred McLoughlin
Executive Director
Sudbury General Hospital
Sudbury, Ontario

Dorothy Pringle, R.N., Ph.D.
Research Director
Victorian Order of Nurses, Canada
Ottawa, Ontario

Rose Rubino
Chairman
National Health Committee
Consumers' Association of Canada
Toronto, Ontario

Hugh E. Scully, M.D.
Associate Professor, Faculty of Medicine,
University of Toronto
Staff Surgeon, Toronto General Hospital
Vice-President, Ontario Medical Association
Toronto, Ontario

Greg L. Stoddart, Ph.D.
Associate Professor and Coordinator
Health Economics and Policy Analysis Group
Department of Clinical Epidemiology and Biostatistics
McMaster University
Hamilton, Ontario

W. Vickery Stoughton
President
The Toronto Hospital
Toronto, Ontario

MINISTRY OF HEALTH LIAISON

David Bogart
Director
Information Resources and Services Branch
Ministry of Health
Toronto, Ontario

STAFF AND PROJECT TEAM

STAFF

Maureen A. Quigley
Executive Director

Gina Thorn
Administrative Officer

Annie Lapid
Secretary

PROJECT TEAM

The following individuals were engaged by the Panel to provide consulting services:

Robert J. Bell
Senior Manager
Peat, Marwick and Partners

Kathleen F. Christie
Partner
Touche Ross

Mark Hundert
President
Medicus Canada

Evelyn Lazare
Principal
Lazare Associates

Steven Raiken
Manager
Peat, Marwick and Partners

Neil Stuart
Senior Manager
Price Waterhouse

Mr. Raiken also served as editor of the Report.

APPENDIX II

LETTER AND NEWSPAPER ADVERTISEMENT REQUESTING SUBMISSIONS AND LIST OF SUBMISSIONS RECEIVED

ONTARIO HEALTH REVIEW PANEL
(Committee to Review the Health Care System in Ontario)

700 Bay Street, 14th Floor
Toronto, Ontario, M5G 1Z6
Telephone: (416) 965-5031

November 26, 1986

Dear Colleagues & Interested Citizens,

On October 24, 1986, Premier David Peterson announced the formation of the Ontario Health Review Panel with the following terms of reference:

"i) to examine the changing patterns of health care in Ontario and trends in health manpower and technology, in relation to changes in the demographic and health profile of the citizens of Ontario;

ii) to examine incentives and mechanisms to maintain the quality and accessibility of health services, to encourage the most effective and economical use of health resources, and to stimulate greater attention to the promotion of health and the prevention of disease;

iii) to examine the relationship between health care professionals and the government with a view to maintaining professional autonomy;

iv) to attempt to identify policies of high priority and to indicate a process for a subsequent stage of in-depth examination of the options for the implementation of these policies."

The first phase of the study, which began on November 12, 1986, will be an overview to identify key issues, set priorities and recommend a process for developing solutions. The second phase would be to implement the more detailed in-depth review process and develop alternative approaches to address the key issues identified.

In order to focus our work from the outset, I have asked each member of the Ontario Health Review Panel to state briefly, in order of priority, the three most important issues which they believe we must identify for the government in Phase 1. At its first meeting, the Panel decided to invite professional associations, interest groups and the public to do the same.

Your advice at this early stage will be of great assistance to the Panel in determining which issues are of greatest concern. In order that your opinion of the three priority issues can receive full consideration by the

Panel, we would greatly appreciate a brief written statement of your views not later than January 5, 1987. Once the issues have been defined, there may be a further, more focussed opportunity for public participation.

We acknowledge the very short interval allowed for your response but we are anxious to have your views at the early, direction-setting stage of the Panel's work.

Sincerely,

JE/aal

John Evans
Chairman

TEXT OF ADVERTISEMENT PLACED IN NEWSPAPERS (December 1986)

PUBLIC NOTICE OF REVIEW OF ONTARIO'S HEALTH CARE SYSTEM

On October 24, 1986, Premier David Peterson announced the formation of the Ontario Health Review Panel to review the health care system in Ontario. The terms of reference are:

i) to examine the changing patterns of health care in Ontario and trends in health manpower and technology, in relation to changes in the demographic and health profile of the citizens of Ontario;

ii) to examine incentives and mechanisms to maintain the quality and accessibility of health services, to encourage the most effective and economical use of health resources, and to stimulate greater attention to the promotion of health and the prevention of disease;

iii) to examine the relationship between health care professionals and the government with a view to maintaining professional autonomy;

iv) to attempt to identify policies of high priority and to indicate a process for a subsequent stage of in-depth examination of the options for the implementation of these policies.

The first phase of the study will identify key issues, set priorities and recommend a process for developing solutions to the issues in phase two.

At this time, we are inviting submissions from persons and organizations interested in health, to aid the panel in the setting of directions and priorities.

We are requesting brief written statements outlining your opinion on no more than three issues, in order of priority, which you believe we should identify for the government in phase one. These should be submitted, no later than January 5, 1987, to:

Ontario Health Review Panel
700 Bay Street, 14th Floor
Toronto, Ontario M5G 1Z6

John R. Evans
Chairman

LIST OF SUBMISSIONS RECEIVED

DISTRICT HEALTH COUNCILS

Algoma District Health Council, Anthony Ubaldi, Executive Director, Sault Ste. Marie

Cochrane District Health Council, Jack Atkinson, Chairman, Timmins

District Health Council of Eastern Ontario, Donald R. St-Pierre, Executive Director, Cornwall

Durham Region District Health Council, Mick Peters, Executive Director, Oshawa

Haldimand-Norfolk District Health Council, James R. Tyrrell, Chairman, Townsend

Halton District Health Council, Ronald Marr, Executive Director, Oakville

Hamilton-Wentworth District Health Council, Robert G. Kirby, D.D.S., M.P.H., Executive Director, Hamilton

Kenora-Rainy River District Health Council, G.A. Ouellette, Chairman, Kenora

Kent County District Health Council, Peter Deane, Executive Director, Chatham

Kingston, Frontenac & Lennox & Addington District Health Council, Elizabeth McIver, Executive Director, Kingston

Lambton District Health Council, A. Beard, Chairman, Sarnia

Metropolitan Toronto District Health Council, Dr. J.R. Nethercott, Chairman, Toronto

Niagara District Health Council, Gary N. Zalot, Executive Director, Fonthill

Ottawa-Carleton Regional District Health Council, Alan Warren, Executive Director, Ottawa

Peel District Health Council, Mary A. Icely, Chairman, Brampton

Rideau Valley District Health Council, Robert Graham, Chairman, Smiths Falls

Thames Valley District Health Council, D.N. Stevens, Chairman, London

Thunder Bay District Health Council, Geoff Weller, Chairman, Thunder Bay

Wellington-Dufferin District Health Council, Sonja Lebans, Chairman, Guelph

HEALTH CARE PROVIDERS

Baker, Dilin, R.N., Toronto

Baycrest Centre for Geriatric Care, Stephen E. Rudin, Executive Director, North York

Byron Family Medical Centre, Toula M. Gerace, R.N., B.Sc.N., Family Practice Nurse, London

Cambridge Memorial Hospital, M. Thompson, Assistant Administrator, Special Programs, Cambridge

Campbellford Memorial Hospital, Richard N. Quesnel, Executive Director and Secretary to the Board, Campbellford

Canadian Home Therapy, Shane Donaldson, President, Whitby

Central Registry of Graduate Nurses, Mary V. Ruth, R.N., Secretary, Board of Directors

Centretown Community Health Centre, Bruce Williams, President, Ottawa

Chedoke-McMaster Hospitals, R.C. Walker, President, Hamilton

Children's Hospital of Western Ontario, Beth Mitchell, Ph.D., C.Psych., Donna Forrest-Pressley, Ph.D., C.Psych., Judy Pollock, M.A.Sc., Margaret Brigham, Ph.D., Alexandra Quittner, M.A., London

Croft, B.B., D.C., Thunder Bay

Dynacare Group, John W. Press, Vice-President, Operations, Toronto

East End Health Centre, James C. Meuser, M.D., Toronto

Franklin, Alexander, M.B., Toronto

Fryters Addiction Consultation Training Services Limited, John Fryters, Ph.D., Addiction Therapist, President, Belleville

Gardien Registry for Nurses, Rose Anne Holness, President, Thornhill

Hamilton Health Sciences Laboratorty Program, R.C. Walker, Chairman, Coordinating Committee, Hamilton

Hastings and Prince Edward Counties Health Unit, P.J. Halket, M.D., D.P.H., Director and Medical Officer of Health, Belleville

Hong Fook Mental Health Service, Mr. Raymond Chung, President, Toronto

Hospital for Sick Children, Dr. J. Donald Morin, Ophthalmologist-in-Chief, Toronto

Hospital for Sick Children Foundation, Claus A. Wirsig, President, Hamilton

Kingston General Hospital Foundation, Sylvia M. Burkinshaw, Kingston

Kingston General Hospital, G.N. Speal, Chairman, Board of Directors, Kingston

Kingston General Hospital, Laurie Thompson, R.N., B.N., Clinic Coordinator, Kingston

Kingston General Hospital, R. Kenneth McGeorge, B.Sc., D.H.A., President and Chief Executive Officer, Kingston

Lake of the Woods District Hospital, Robert K. Muir, M.A., D.P.P.E., Executive Director, Kenora

Lawrence Heights Medical Centre, Saul Cowan, President, Toronto

Leonoff, Arthur, Ph.D., C.Psych., Ottawa

London West Chiropractic Centre, R.J. Dronyk, D.C., N.D., London

Lyndhurst Hospital, A.T. Jousse, M.D., F.R.C.P.(C), Toronto

Middlesex-London District Health Unit, Sandra Mackenzie, Public Health Nursing Supervisor, London

Minister's Advisory Committee, Reproductive Care - Province of Ontario, John Patrick, M.D., F.R.C.S.(C), Chairman, London

Moulton, Richard, M.D., Fort Frances

Mount Sinai Hospital, I.H. Koven, M.D., Toronto

North York General Hospital, R. Gershater, M.B., F.R.C.P.(C), Chief, Department of Diagnostic Imaging, Willowdale

Orthopaedic and Arthritic Hospital, Roger C. Sharman, President, Toronto

Oshawa General Hospital, B. George Blake, Ph.D., Director, Department of Psychology, Oshawa

Peat, Robert S., M.D., Downsview

Porcupine Health Unit, W.M. Coulby, D.D.S., D.D.P.H., Director of Dental Services, Timmins

Richards, Robert N., M.D., F.R.C.P.(C)

Sackett, David L., M.D., F.R.C.P.(C), Hamilton

St. John Ambulance, Catherine Knox, Chairman, Health Care Committee, Toronto

St. Joseph's Health Centre, Margaret Miles, President, Patients' Council, Fred Peterson, Past President, Toronto

St. Joseph Health System, Sister Janet Murray, President, Willowdale

St. Joseph's Hospital, Sister Joan O'Sullivan, Executive Director, Hamilton

Sudbury Memorial Hospital, G.R. Walker, M.D., Chief of Staff, Sudbury

Sudbury Memorial Hospital, P.J. Van Boxel, M.D., F.R.C.S.(C), Sudbury

Sunnybrook Medical Centre, Martin Barkin, M.D., B.Sc., M.A., F.R.C.S.(C), President and Chief Executive Officer, Toronto

Toronto General Hospital, Dr. H.R. Devlin, Department of Microbiology, Toronto

Township of Osgoode Care Centre, Gordon Scrivens, President, Board of Directors, Metcalfe

Tyler, Joan, M.D., Elliot Lake

University Hospital, Margaret T. Hearn, Ph.D., C.Psych., Chief, Department of Psychological Services, London

Victoria Hospital, G.M. Weisz, Ph.D., London

Waterloo Regional Homes for Mental Health Inc., Wendy Czarny, Executive Director, Kitchener

HEALTH SCIENCE CENTRES

Council of Ontario Faculties of Medicine, Frederick H. Lowy, M.D., Chairman, Toronto

McMaster University, Faculty of Health Sciences, G.H. Flight, M.D., Dean (Acting), Hamilton

McMaster University, Dr. Peter B. Dent, Department of Paediatrics, Hamilton

McMaster University, K.C. Finkel, M.D., F.R.C.P.(C), Professor of Paediatrics, Hamilton

McMaster University, John I. Frid, M.D., Associate Clinical Professor, Health Sciences Education Centre, Hamilton

McMaster University, K. Ross Parker, M.D., Professor, Family Medicine and Paediatrics, Hamilton

Queen's University, A.J. Baumgart, Dean, School of Nursing, St. Lawrence College, M. Johnson, Dean, Health Sciences, Kingston

Queen's University, Continuing Medical Education, A.M. Bryans, Director, Kingston

Queen's University, C. Robin Walker, M.B., Ch.B., F.R.C.P.(C), Assistant Professor, Department of Paediatrics, Kingston

Queen's University, Marjorie Boyle, M.B., F.R.C.(C), Associate Professor of Paediatrics, Kingston

University of Ottawa, J.M. Forster, M.B., C.C.F.P., F.C.F.P., Professor and Chairman, Department of Family Medicine, Ottawa

University of Ottawa, Jane Fulton, Ph.D., Assistant Professor, Ralph W. Sutherland, M.D., Associate Professor, Ottawa

University of Toronto, Charles H. Hollenberg, M.D., Vice-Provost, Health Sciences, Toronto

University of Toronto, Faculty of Medicine, Karin Domnick Pierre, Paradigm Health, Toronto

University of Toronto, Faculty of Dentistry, James L. Leake, D.D.S., D.D.P.H., M.Sc., D.W. Lewis, D.D.S., D.D.P.H., M.Sc., F.R.C.D.(C), D. Locker, B.D.C., Ph.D., J.T. Mayhall, D.D.S., Ph.D., Toronto

University of Toronto, Faculty of Medicine, Clive B. Mortimer, F.R.C.S.(C), Professor and Chairman, Department of Ophthalmology, Toronto.

University of Toronto, Faculty of Medicine, C.P. Shah, M.D., F.R.C.P.(C), Professor, Toronto

University of Toronto, M.J. Ashley, M.D., Professor and Chairman, Department of Preventive Medicine and Biostatistics, Toronto

University of Toronto, Eugene Vayda, M.D. Associate Dean, Community Health, Toronto

University of Toronto, D.G. Potts, Professor and Chairman, Toronto

University of Toronto, D.M. Goldberg, M.D., Ph.D., Department of Biochemistry, M.D. Silver, M.D., Ph.D., Department of Pathology, L.P. Spence, M.D., F.R.C.P.(C), Department of Microbiology, Toronto

University of Toronto, D.H. Cowan, M.D., F.R.C.P.(C), Chairman, Oncology Coordinating Council, Toronto

University of Toronto, Gerard N. Burrow, M.D., Sir John and Lady Eaton Professor and Chairman, Department of Medicine, Toronto

University of Toronto, C.R. Woolf, M.D., F.R.C.P.(C), F.R.C.P., Assistant Dean, Continuing Education, Faculty of Medicine

University of Western Ontario, D. Bocking, Vice-Provost, Health Sciences, London

University of Western Ontario, Daniel Ling, Dean, Applied Health Sciences, London

University of Western Ontario, I.R. McWhinney, M.D., FCFP, FRCP, London

University of Western Ontario, Joan M. Gilchrist, Professor and Dean, London

University of Western Ontario, W.B. Chodirker, M.D., Assistant Dean, Clinical Affairs, London

INDIVIDUALS

Aitkens, Andrew, Research Consultant, Nepean

Aston, A., Kitchener

Baer, Rayond E., Kitchener

Bell Kathlene, Windsor

Benson, Pamela, M.S.W., Kingston

Bergeron, Hope, Scarborough

Bergin, Betty, Ottawa

Bottrell, E.H., Kingston

Brooks, William J., P.Eng., Niagara Falls

Brown, D. Ruth, London

Brown, G.M., London

Burrows, R., President, Burrows Medical Oxygen Ltd., Toronto

Charron, Raymond L., Windsor

Day, Jean, Sarnia

DeSylva, Richard, C.H., The Herb Works

Elek, Andrew, Toronto

Faith, Karen, M.Ed., Thornhill

Falkner, Susan, M.S.W., Kingston

Gorr, O.E., Pembroke

Greenaway, Florence, Guelph

Guinn, A., Hawkestone

House, Nadine, Guelph

Hunte, Ruby, Scarborough

Ladyshewsky, Richard, Toronto

Lougheed, H.A., Willowdale

McCulloch, Earl and Jo, Cobourg

McNiece, David E., Lembeth

Midgette, Judith Anne, R.P.Dt., Toronto

Mitchell, I.H., Kleinburg

Muril, Wolf, Toronto

Niblett, Vicki, Oakville

Niblitt, Mark, Frankford

Oki, Gus, Toronto

Palef, Beverly, Toronto

Panimondo, Joe, Toronto

Parsons, Kenneth N., Kitchener

Paulitzki, Karen, Cambridge

Perris, Mary-Kay, Toronto

Phillips, Margaret J., Peterborough

Ritchie, Thomas, White Lake

Rolls, W.F., Bonfield

Ross, Mary Lou, Tavistock

Seckington, Harold, Leamington

Sharman, Roger C., Oakville

Stagg, Mark B., Parry Sound

Taylor, Ed and Ann, Cobourg

Tetu, G.E., Stratton

Walsh, Peter J., Etobicoke

Watson, Donald, Ottawa

Webster, Dan A., Wingham

Whitehead, Norma, Toronto

ORGANIZATIONS

Allergy Information Association, M. Susan Daglish, Executive Director, Weston

Alzheimer Association of Ontario, Eileen Bigley, Executive Director, Toronto

Amyotrophic Lateral Sclerosis Society of Canada, Myra Rosenfeld, President, Toronto Area Chapter, Toronto

Association of Concerned Citizens for Preventive Medicine, Ron J. Dugas, President, Ottawa

Association of Ontario Health Centres, Mark McGuire, Executive Director, Islington

Association of Treatment Centres of Ontario, Alice M.T. Johnson, President, Board of Directors, Mississauga

Board of Directors of Drugless Therapy, Eric F. Shrubb, D.C., N.D., Chairman, Scarborough

Board of Education for the City of Toronto, Dr. Edward N. McKeown, Director of Education, Toronto

Canadian Hearing Society, Denis Morrice, Executive Director, Toronto

Canadian Hemophilia Society, William Mindell, B.G.S., M.P.H., Chairman, Medical, Scientific and Public Health Issues Committee, Ontario Chapter, Toronto

Canadian Pensioners Concerned, Ontario Division, Jean R. Woodsworth, President, Toronto

Canadian Red Cross Society, Janet Jones, President, Toronto

Canadian School of Management, Erwin Waschnig, M.B.A., Ph.D., Director, Health Services Administration Program, Toronto

Canadian Wholesale Drug Association, Desmond Lartigue, President, Montreal

CANDIDA Research Information, David Lidov, Toronto

Citizens for Public Justice, Gerald Vandezande, Public Affairs Director, Toronto

City of Toronto Housing Department, George C. Cook, Commissioner, Toronto

Committee for Oxford County Physically Handicapped, Muriel Norcross, Corresponding Secretary, Woodstock

Consumer's Association of Canada (Ont.), Celia Gibbs, Chairman, Health Committee, Thunder Bay

Easter Seal Society, F. Howard Keast, President, Don Mills

Heart and Stroke Foundation, Anthony F. Graham, M.D., F.R.C.P.(C), President, Toronto

House of Friendship, Martin Buhr, Executive Director, Diane B. Ritza, Community Support Worker, Kitchener

London and Middlesex Association for Children and Adults with Learning Disabilities, Helen Polatajko, Chairperson, London

London Life Insurance Company, Charles L. Kimball, Vice-President, Group Insurance, London

Metro Toronto Multicultural Mental Health Group, Reverend Robert P. Alexander, Chairperson, Toronto

Multicultural Health Coalition, R. Masi, President, Downsview

Oakville South Provincial Liberal Association, W. Campos, President, Oakville

Office of Francophone Affairs, Remy M. Beauregard, Executive Director, Toronto

Ontario Advisory Council on the Physically Handicapped, Ronald W. McInnes, Chairman, Toronto

Ontario Association for Children and Adults with Learning Disabilities, Eva Nichols, Toronto

Ontario Association of Children's Mental Health Centres, W.M. Rothery, President, Toronto

Ontario Association of Family Service Agencies, Paddy Ann Pugsley, Executive Director, Toronto

Ontario Association of Homes for the Aged, Robert A. Morton, President, Woodbridge

Ontario Association of Medical Laboratories, Roger D. West, LL.B., Executive Director, London

Ontario Chamber of Commerce, J.A. Sanderson, President, J.G. Carnegie, General Manager, Toronto

Ontario Coalition for Nursing Home Reform, Verna Steffler, Chairman, Weston

Ontario Friends of Schizophrenics, June Conway Beeby, Executive Director, Toronto

Ontario Health Coalition, Michele Harding, Toronto

Ontario Home Oxygen Supplier's Association, Inc., Kevin J. Nichols, President, Toronto

Ontario Nursing Home Association, Harvey M. Nightingale, President, Willowdale

Ontario Society for Autistic Citizens, Jane McLean, Reg.N., Executive Director, Thornhill

Ottawa-Carleton Health Coalition, Pat Deline

Panova Institute for Health Promotion Inc., James Collishaw, Thornhill

Planned Parenthood Ontario, Ellen Barr, Ph.D., President, Hamilton

Provincial Council of Women of Ontario, Donalda Broadhurst, Toronto

Service Employees International Union, S.E. Roscoe, International Vice-President, Toronto

Social Planning Council of Metropolitan Toronto, Robert Doyle, Ph.D., Senior Program Director, Toronto

Social Planning Council of Ottawa-Carleton, Reverend Peter Schonenbach, President, Ottawa

Thunder Bay and District Health Coalition, Prue Morton, Secretary, Thunder Bay

Toronto Mayor's Committee on Aging, Amy Thompson, Chairperson, Health and Well Being Sub-committee, Toronto

United Senior Citizens of Ontario, Jane Leitch, Corresponding Secretary, Toronto

VIEWS for the Visually Impaired, Vera Malec, Acting Executive Director, Mississauga

VOICE Ontario, Mary Fox, Executive Director, Toronto

PROFESSIONAL ASSOCIATIONS

Association of Allied Health Professionals: Ontario, Catherine E. Bowman, Executive Director, Toronto

Association of Nurse Executives of Metropolitan Toronto, Marie Jefferson, President, Toronto

Association of Nursing Directors and Supervisors of Ontario Official Health Agencies, Christine Denn, President, Willowdale

Board of Directors of Chiropractic, E.R. Burge, D.C., Vice-Chairman, Toronto

Canadian Physiotherapy Association, Nancy Christie, Executive Director, Toronto

College of Family Physicians of Canada, Nick Busing, M.D., F.C.F.P., President, Ontario Chapter, Ottawa

College of Nurses of Ontario, Margaret Risk, Reg.N., Executive Director, Toronto

College of Optometrists of Ontario, Irving Baker, O.D., Registrar, Toronto

Council of Ontario Nurse Executives, Mary E. MacInnis, Vice-President, Nursing, London

Essex County Medical Society, Thomas F. Draisey, M.B., Ch.B., F.R.C.P.(C), President, Windsor

Institute of Chartered Accountants of Ontario, Peter E. Held, FCA, President, Toronto

London Regional Psychological Association, William Newby, Ph.D., C.Psych., President, London

Medical Reform Group of Ontario, Michael M. Rachlis, M.D., Toronto

Ontario Association of Chiropodists, Peter G. Guy, B.Sc., D.Ch., President, London

Ontario Association of Optometrists, Marvin Nash, O.D., President, Toronto

Ontario Association of Professional Social Workers, Sharon McKay, M.S.W., C.S.W., President, Toronto

Ontario Association of Registered Nursing Assistants, Verna Steffler, R.N.A., Executive Director, Weston

Ontario Chief Psychologists Association, Margaret T. Hearn, Ph.D., C.Psych., President, London

Ontario Dental Association, John C. Gillies, B.A., C.A.E., Executive Director, Toronto

Ontario Dental Hygienists' Association, Laura Dempster, President, Hamilton

Ontario Dietetic Association, Eleanor Brownridge, R.P.Dt., President, Toronto

Ontario Hospital Association, Gordon R. Cunningham, President, Don Mills

Ontario Medical Association, J.B. Cullen, M.D., F.R.C.P.(C), Chairman, Section on Laboratory Medicine, Toronto

Ontario Naturopathic Association, Patricia J. Wales, D.C., N.D., President, Etobicoke

Ontario Nurses' Association, Donna Alexander, Reg.N., President, Toronto

Ontario Occupational Health Nurses Association, B.Harris, Reg.N., CCOHN, President, Hamilton

Ontario Pharmacists' Association, R.B. Franceschini, Executive Director, Toronto

Ontario Physiotherapy Association, Karen Fryday-Field, President, Toronto

Ontario Psychological Association, D.R. Evans, Ph.D., C.Psych., President, Toronto

Ontario Public Health Association, Dr. Trevor Hancock, President, Toronto

Ontario Society of Medical Technologists, Patricia Blake, President, Toronto

Ontario Society of Nutritionists in Public Health, Sandy Marsden, R.P.Dt., M.H.Sc., Chairperson, Toronto

Registered Nurses Association of Ontario, Barbara Fletcher, R.N., B.Sc.N., Chairperson, Kingston Region, Kingston

Registered Nurses Association of Ontario, Pat Kirby, Reg.N., President, Toronto

APPENDIX III

LIST OF GOVERNMENT OFFICIALS AND OTHER INDIVIDUALS INVITED TO MAKE PRESENTATIONS TO THE PANEL

APPENDIX III

LIST OF GOVERNMENT OFFICIALS AND OTHER INDIVIDUALS INVITED TO MAKE PRESENTATIONS TO THE PANEL

GOVERNMENT OFFICIALS

Ministry of Colleges and Universities

- Alan Adlington
  Deputy Minister

- Ralph Benson
  Assistant Deputy Minister
  Colleges and Student Support Division

- Elaine Hykawy
  Health Science Co-ordinator
  Universities and Research Support Division

Ministry of Community and Social Services

- Peter Barnes
  Deputy Minister

- Gerry Duda
  Assistant Deputy Minister
  Community Services Division

Ministry of Health

- Honourable Murray Elston
  Minister

- Dr. Allan Dyer
  Deputy Minister

- Mary Catherine Lindberg
  Assistant Deputy Minister
  Policy Planning and Systems

- David Corder
  Assistant Deputy Minister
  Mental Health
  Assistant Deputy Minister (Acting)
  Community Health

- Randy Reid
  Assistant Deputy Minister
  Institutional Health

- Ron LeNeveu
  Assistant Deputy Minister
  Administration, Finance and Health Insurance

- Dr. Dennis Psutka
  Assistant Deputy Minister
  Emergency and Special Health Services

Ministry of Labour

- Glenn Thompson
  Deputy Minister

- Len Haywood
  Chief Economist
  Industrial Relations Division

- Arthur Gladstone
  Acting Executive Director
  Occupational Health & Safety Division

- Peter Sadlier-Brown
  Assistant Deputy Minister
  Labour Policy and Programs Division

- Victor Pathe
  Assistant Deputy Minister
  Industrial Relations Division

Ministry of the Environment

- Rod McLeod
  Deputy Minister

- Walter Giles
  Associate Deputy Minister
  Intergovernmental Relations and Strategic
  Projects Division

- Dr. David Balsillie
  Assistant Deputy Minister
  Environmental Services Division

- Dennis Caplice
  Assistant Deputy Minister
  Operations Division

Ministry of Tourism and Recreation

- Ruth Cornish
  Director
  Strategic Policy Branch

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- Dr. Shiu Loon Kong
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- Henry McErlean
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- Tom Campbell
  Former Deputy Minister of Health, Ontario (1979-1981)

- Graham W. Scott
  Former Deputy Minister of Health, Ontario (1981-1985)

- Dr. Brian Holmes
  Former Chairman
  Ontario Council of Health

- Dr. Fraser Mustard
  President
  Canadian Institute for Advanced Research

- Dr. Jean Rochon
  President
  Commission d'Enquete Sur Les Services De Sante et les Services Sociaux, Quebec

APPENDIX IV

BIBLIOGRAPHY OF KEY REFERENCE DOCUMENTS

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